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And liquid lapse of murmuring streams.

—John Milton

POSTMAN'S HOLIDAY

"HOW WONDERFUL to be back in the city!" says the country mouse (excuse us, we meant the country nurse), ecstatically gazing at the tall buildings and the bustling traffic.

"How glorious to be back in the country!" sighs the city lass, contentedly drinking in the fresh, clean air and the green hills.

What, indeed, is the value of a holiday, unless it gives us a change—physically or mentally or both—from our workaday surroundings and habits; unless it sweeps the cobwebs from our thinking, jars us out of ruts, gives us fresh perspective on old problems?

"What are you doing for vacation this year?" becomes almost as common a question as "How are you?" as summer days approach. Here, if ever, one person's meat is another's poison. Each must choose what for him *is* in truth a vacation. Miss Brown can hardly wait to get into slacks and old togs and leave civilization behind. Miss Smith thinks of smart restaurants and gay music as she shops for a new dinner dress.

Each is seeking for the relaxation and enjoyment which brings a renewal of energy and a fresh impetus to the coming year's work. Now that nurses can usually count on a month's vacation—a period which most agencies realize is a sound investment in better community service—the problem is, "How can I get best returns for my money and time?"

Some useful suggestions by experts are found in a vacation article in the June *Rockefeller Center Magazine*, New York City. It quotes a budgetary specialist as advising that an average young person spend 11 percent of his annual income on improvement, of which about half may go to the summer vacation. The same authority suggests that persons with limited incomes take an inexpensive vacation one year and a "fancy vacation" the next.

A travel expert gives additional advice. "If you want a rest, stay in one spot; if you like change, plan a train trip stopping lots of places, or an air cruise. . . . If you're on a limited budget, don't spend too much on traveling and don't go too far away." Vacations available on budgets all the way from $50 to $1000 are suggested—from bicycling through country roads and stopping overnight at farm houses to a cruise, a dude ranch, or a trip abroad. And of course the nurse with a car has the world at her door!

The N.O.P.H.N. wishes you a happy holiday which will bring you new zest for living during the year to come.

P.P.

A NEW-FASHIONED FOURTH

WITH the Fourth of July now close at hand, safety organizations are issuing warnings against the use of dangerous fireworks. The hazard of eye injuries and blindness is stressed by Lewis H. Carris, Managing Director of the National Society for the Prevention of Blindness, who states that "there are now in American schools for the blind nearly 500 children who lost their sight as a result of accidents, chiefly through the use of fireworks and air rifles."

Instead of the old-fashioned Fourth heralded at dawn by the popping of firecrackers, it is suggested that parents plan the holiday by organizing picnics, clambakes, impromptu parades, amateur ball games, and regattas, perhaps ending in the evening with community fireworks' displays under the supervision of an adult. In this way, children may enjoy the celebration of the signing of our Declaration of Independence without being exposed to such hazards as loss of sight, loss of limb, or disfigurements.

Social Planning for Family Health

By BRADLEY BUELL

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The real issue in community planning is the family, for whom we want to secure better health and to provide any service needed to improve the level of its family life

FOR A NUMBER of years my job has involved an effort to get some picture of the total programs which communities are financing and administering in order to provide not simply better family health, but better family life. You would be surprised at the complexity of that task. When you add to the different kinds of social service that relate directly to family health the services that are concerned with the social and economic problems of families, of adults, and of children, and the services that provide recreational and cultural opportunities for their leisure time, you get a picture of organization and service which in size, complexity, and cost is rudely sobering.

Take, for example, a middle-sized community of a quarter-million population, with which I am familiar. The total annual bill for the services that deal with problems of health, relief, family welfare, child care, and recreation is over $8,000,000—$33 for every man, woman, and child of the population. Fifty-one percent of that was for relief and family welfare, 33 percent of it was for health, 10 percent for child care, 6 percent for recreation. Of that $33, about $7 came from earnings, fees, and the like, $6 came from private contributions, and $20 from various kinds of tax funds. Nearly $7 of this tax money was from federal sources, nearly $6 from state money, and another $7 from city money. (In this particular community there were practically no county expenditures for these purposes.) This $8,000,000 is administered by 113 separate independent administrative units, public and private. Some of the governmental agencies are controlled from Washington, some from the state capital, some by the city. Some of the private agencies are statewide but most of them are restricted to the city. Some of the city agencies serve the metropolitan area outside the city, and some do not. Most of the private agencies are members of the community chest, but there are several important ones which have independent sources of income.

Now, experience with this effort to see the total picture, and to understand some of the principles of program, organization, and finance that are common to all of the special fields of service that are included in it, does not make me competent to bring to you a community plan for family health. That involves a technical knowledge which I do not have. Perhaps, however, it does warrant my making some general observations about the broad problems involved in making such a community plan, and about the part which you, as representatives of nursing organizations, and we, as community chests and councils, can play in that process.

A plan for family health should, I believe, be part of a community plan for family welfare, and should be closely correlated with planning for the social and recreational needs of those same families. Only as you see all that the community is doing for family life, can you truly understand what it is doing

for family health. To put it more concretely, your ultimate professional function as nurses, and the organization function of the visiting nurse association or of the nursing division of the health department can only be seen as part of a coherent analysis of what these 113 separate units in this particular community are doing—and why. Let me illustrate the statement in two different ways.

THE O'BRIEN FAMILY

In the first place, we who are interested in these problems of community planning are sometimes too prone to present them in organization terms—to speak profoundly of duplication between agencies, coördination of services, differentiation or specialization. But the real issue is the family for whom we want to secure aids to better health or any other special service to improve the level of its family life.

Go into any social service exchange anywhere and pick out a handful of cards. You will find one, I'm sure, from which you may deduce that Patrick O'Brien and Mary O'Reilly were married about fifteen years ago, because late in that year the visiting nurse association was first registered for care attendant upon the birth of John. During the next three or four years you will find more V.N.A. registrations, with a little Mary and a Daniel added to the family list. You will guess that the mother Mary was not very well during part of that period, for there is a hospital inpatient registration. From a family welfare registration at that time you will suspect that the problem of keeping the family together while she was away was a little too much for their own abilities. At the end of five or six years you will certainly find from another V.N.A. registration that a little Patrick had been added to the group. In this same period, which would be 1930 or 1931, you could assume that Patrick, the elder, lost the steady job he had always had, for the department of public welfare appears and reappears intermittently through 1934, as do also the bureau of Catholic charities, the family welfare society, the American Legion, and the American Red Cross—an indication that Patrick was determined that if he couldn't get a job he would get as much relief as he was able. And apparently the health of the family has not improved under these economic circumstances, for there is a registration from the tuberculosis association, and some additional ones from the visiting nurse association and hospital social service which do not seem to be attendant upon new additions to the family.

By this time John is ten years old and does not seem to be doing so well in school, for the visiting teacher is on the card. The strain of unemployment and of these other difficulties seems to have become acute, for the society for prevention of cruelty to children and the children's bureau are recorded, indicating that some protective service or foster-home care has been called for. But apparently that did not take care of the situation. For in 1936 John or Mary must have gotten into the juvenile court, since there is its registration along with that of the mental hygiene clinic.

Pick out your own card in your own exchange and read between its lines. The O'Brien family is really a pretty good family with a great deal of grit and capacity for punishment. My point is that here is the end result for which you need community planning. It is because of the needs of such families as this that we must know whether or not there are in the community the proper specialized resources and facilities; that we must know whether the families really get them when they are needed and not at a date too late to be of any use; that we must be assured that the people who are giving them are not stepping on each other's toes, and that several of them are not doing pretty much the same sort of thing. To the nurse, Mary's tubercu-

losis is a specialized problem calling for technical diagnosis, treatment, and supervision. To the children's agency Johnny's delinquency is a specialized problem calling for psychiatric diagnosis, for coöperation by the schools, and for special supervision in some group-work agency. But to the family, these are only episodes, incidents of varying importance in the whole stream of its family life. The physician's orders for Mary's tuberculosis might make it physically and economically impossible to follow the treatment which would resolve the reasons for Johnny's delinquency. Hospital care for the mother did create problems that the family were unable to meet.

Over the period of a family's history as an entity, these individual specialized services inserted periodically and separately can only create ripples in the life-stream of any family. Only by weaving them together in a single fabric do we have any chance at all of changing the course of that stream. Fundamentally that is why we must talk about community planning—why it is important to see each special service, each individual administrative unit, in its relation to the whole.

EXPERIENCE FROM HEALTH FIELD

I will now take a quite different sort of illustration from your own health field. The public health appraisal form is, in my judgment, the best effort so far made by any group to see even one part of this field of community service in its totality. Based as it is on a pattern of technical services—medical, nursing, institutional, educational, diagnostic, and therapeutic—it outlines the relationship of these services to the specific problems of maternal and infant health, preschool and school health, tuberculosis, syphilis and other communicable disease. I know that the development of this pattern has been of significant assistance in clarifying your own nursing functions. I know also that the presentation of the whole public health program as a unit is one of the best ways to make a community recognize the importance of an adequate public health nursing program. It has demonstrated the validity of the principle that you need to see as much of the whole program as you can in order to plan soundly for any of its parts.

But it also illustrates, I believe, the limitations of segmented planning, even though the segment may be a broad and complex one. The O'Brien family needed hospital service. I am very sure that over the period of fifteen years they needed medical attention in the home, and that if they couldn't pay for it they probably did not get it from the city physician. It would seem quite likely that some of them needed dental care, and unless this city were more blessed than most, they probably had a pretty difficult time in getting that. The preventive health program is important, but to family health it is no more important than the program for the care of people after they become sick.

But as I go about, I am impressed with the fact that in no part of our community programs is there greater confusion or lack of planning than in this curative area of family health. Hospitals, not only as a group but as individual units, have been a law unto themselves. They overbuilt in the twenties and have gone broke in the thirties. Those persons who were unable to pay for hospital care have been the traditional beneficiaries of hospital profits, and only as these profits dwindle are we commencing to get a real consideration of a complete program either for our relief families or for the medically indigent in the marginal economic group. In most communities there is little rational plan in the allocation of financial and administrative responsibility. Standards in respect to the volume and distribution of dispensary care necessary for a community are nonexistent. I am not at all sure but that the able and persistent development of our public

health program has tended to absorb available leadership, to obscure the problems which exist in other parts of the health field, and push them into the background of community consciousness.

Certainly I am sure of this: The function of the visiting nurse association and of the department nursing service would be very much clearer—their scope, I suspect, very much enhanced—if we had behind us as much orderly thinking about the organization of all our health services as we have had about those which relate specifically to preventive health.

To take only two examples: Financing of the child welfare program is generally recognized (if not always practically accepted) as the responsibility of the health department. But payment for bedside care to those who cannot afford to pay for it themselves is recognized as no one's responsibility, and is in the main provided only by deficit appropriations from community chests or from private funds contributed for that same purpose. Very few communities have analyzed or faced this problem.

Or take another example of a different sort. In connection with one of our surveys a number of years ago, I asked the local nursing executive if she got many referrals from out-patient departments or clinics. She did not know; thought they probably did; and later found they did not. And yet it seems to me that coöperation between the nursing agencies and not only the clinics but also the in-patient departments to which people come for diagnosis and treatment is just as important as coöperation between those special tuberculosis and syphilis clinics that are part of the preventive health program.

NURSING AGENCIES CAN CONTRIBUTE

If it is agreed that planning for family health should be an intrinsic part of planning for the betterment of other aspects of family life, what can the representatives of local nursing agencies and the representatives of community chests and councils do about it in the communities from which they come?

There are two major contributions to community planning in the health field which your professional group has made in recent years. The first is generalized nursing. While I may only suspect that it has been a real factor in improving the quality of all nursing, I *know* that it has been a real factor in better community planning. This is true not simply because it removes the likelihood that two or three different kinds of nurses will appear simultaneously in the O'Brien family, but perhaps more fundamentally because it has removed jealousies, vested interests, and hair-splitting controversies over distinctions without a difference—all of which tend to confuse community leaders and divert them from the central issue of how to provide the families of the community with the nursing service that they need. I have indeed at various times had occasion to use this achievement in the nursing field as an example which the case workers would do well to follow. In our normal community of a quarter of a million, we will probably find at least ten or a dozen different kinds of specialization in the case-work field, separately administered, separately financed, often in obvious conflict. This, in my judgment, is a primary barrier to the community acceptance and development of the case-work function, and you are to be congratulated for having passed through that stage.

The second contribution of the nursing group is this: While some of the issues that relate to the administration and financing of nursing service through the schools, the health department, and the visiting nurse association may still be unresolved, yet the generally accepted principle that there should be no more than three nursing units in the community, that two are preferable, and that under any circumstances it is essential to work out various devices that will

ensure close coördination between these units and establish clear-cut divisions of responsibility, is a great step in the direction of better community planning.

GREATER CONTRIBUTION POSSIBLE

In two respects, however, it seems to me that many nursing groups can make a greater contribution to local planning than they are making now. The first applies perhaps more particularly to the private agency with its volunteer board and citizen constituency. As part of the daily performance of its task it touches powerful forces in the community: government and politics, through its close relationship to the public health program; the medical profession, of course; employers, because of the service it gives to the families of the men and women who work for them; labor unions, because of that same service to people who are their members; the press, because better community health and the care of people when they are sick is the most appealing and least controversial of all needs which our community programs intend to meet.

All of these people know about nursing and respect its usefulness. Yet all too frequently the visiting nurse association board and staff seem content to rest upon the acceptance by the community of the competent performance of their own specific tasks. There are many communities where the visiting nurse association has seemed to stand out above all other health agencies in the technical quality of its performance, and yet has seemed to play little or no part among those community leaders who were striving for a more adequate total health program. Leadership in community planning is where you find it. It may be resident in the official department, in leading members of the medical profession, or in the superintendents of leading hospitals. I have, however, seen communities where the attitude and coöperation of the medical profession, the policies of the hospitals and the public officials towards medical care, and the degree of coöperation between the health workers and the social workers are mainly attributable to the leadership given to the community over a period of years by the professional staff and the board of the public health nursing association. I think that these instances should be increasingly multiplied.

STRATEGIC POSITION OF NURSE

My second point is in respect to the equally strategic position which the individual nurse, as distinct from the organization for which she works, occupies in relation to families like the O'Briens. Over the period of fifteen years, nurses probably visited that family more often than did the representatives of any other community agency. In any community normally equipped, nurses will visit more families in their own homes in a given year than the representatives of any other agency except the department of public welfare with its present huge relief load. Moreover, many of the families which the nurses visit are those from which come the majority of the social as well as the health problems of the community.

I cannot but feel that this has a very great implication in relation to our planning for better family health—and family life. The strain of unemployment and of illness in the O'Brien family began to show long before Johnny got into the juvenile court. At what point did the nurse discover that this difficulty was developing? Did she ever discover it? Did she make her own diagnosis and give her own treatment for the social situation, or did she call for help, and to whom?

Case finding is a term with which you are all familiar. Just as the early discovery of health problems is part of any program for family health, so is the early discovery of social problems essential to any program for better family life. Collectively the nurses of a com-

munity have a better opportunity to contribute at this point than almost any other professional group. In some of our community surveys we have tried to analyze referrals back and forth between the nursing and case-work agencies. Invariably the volume of referrals from the nursing association to the family agencies has been considerable. But invariably, also, the referrals have been mainly for relief, or because of economic problems.

In instances where the nursing association had available a psychiatric consultation service, it was apparent that the field nurses were developing an ability to recognize more serious mental problems in the family and the earlier stages of personality difficulties and conflicts. Yet here again, the families which were referred to the case-work agencies were still mainly those where relief was the primary problem, rather than those cases where skilled service could build upon positive factors in the total family situation.

The reverse was equally true. The volume of referrals from the case-work agencies to nursing and other health resources was also great. But systematic provisions for physical examinations were apt to be lacking; referrals were made for treatment instead of diagnosis; and there was failure to follow through in coöperation with the medical agency upon the health problem.

In terms of the problems of the O'Brien family—or any other—these failures not only represent waste motion but may be even more serious than that. Better community planning implies that the specialized services which project themselves into a family situation should be able to recognize the surface indications of problems which may exist; that each service should appreciate its responsibility towards the total situation in the family and be prepared to play its part in securing a diagnosis which will bring to light *all* of the problems that the family has; and equally, I think, that each should recognize that it should not try to diagnose or treat problems that lie outside the area of its own specialty.

COMMUNITY CHESTS AND COUNCILS

Community planning for family health comes down to earth in the individual local community. Better patterns need to be developed, it is true. Many of the questions of organization, procedure, and method are yet unsolved. But any given community must measure future progress from the point at which it now happens to be. Webster's dictionary defines a plan as a "program for action," and action involves not only ideas and leadership, but a machinery through which these can function.

And so I should like to say a few words about community chests and councils of social agencies. Four hundred and fifty cities today have some sort of chest or council or both, and they practically occupy the urban territory of this country. I have no apologies to make for them. Some are very good; some are very bad; a great many are undoubtedly indifferent. But I believe in most communities these things are true: (1) The citizen leadership behind them is pretty representative of the best citizen leadership that the community affords; (2) The responsibility for budgeting and finance exerts a steady pressure upon this group to see more and more of the total community picture of public as well as private services; (3) The council particularly, with delegate representation from all public and private agencies, affords a practical—and so far the best—medium for anyone who has the ability to exercise leadership for any aspect of social planning.

It is in the main true that chests and councils have been less accustomed to plan for health than for any other field. There are many practical reasons for this. Relief problems have been dramatically to the fore since the depression began, and have insistently demanded

priority of energy and attention. But also, leaders in the health field have tended to regard their own interests and responsibilities as separate from the social services of traditional charity, and have looked upon councils of social agencies as the heritage of that originally restricted area. Witness, for example, the number of hospital councils that are organized separately from the central councils.

I might add another reason with some seriousness. The scientific terminology of the case workers and even of the group social workers is baffling enough to those of us who are mere executives or community organizers, but when we are confronted with the language of that complex variety of specialists who play their part in the health services, we are simply overawed. But I am increasingly convinced that the basic problems of community organization and community planning are much the same for all; that there is no more mystery about organizing the community for better family health than for any other aspect of family life. And so I hope that you will have some patience with your chest and council secretaries. They may not know much about medical services, but if they are any good at all they will know a lot about your community and how to get things done within its resources and with the leadership that is practically available.

In any case, this situation is steadily changing. Health sections of central councils are increasing in numbers and in the effectiveness of their programs. The larger cities are adding people to the central staff who have had special experience in the health field. Both in the national agencies, including your own National Organization for Public Health Nursing, and in the local communities, leaders for better health are recognizing that this central machinery which now so largely occupies our urban territory does afford a practical instrument for planning.

This machinery certainly is not perfect. But it is yours to use. The future of local planning for family health will, I suspect, be largely dependent upon the knowledge, the resourcefulness, and the leadership that you and others who are specialists in your field put into the effort to make this machinery serve your ends.

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Pathogenesis of Tuberculosis

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What are the three fundamental tissue reactions in tuberculosis? How do symptoms arise? How does reinfection develop? A complex subject is discussed here with remarkable clarity

SINCE Robert Koch discovered the tubercle bacillus in 1882, the term *tuberculosis* is applied to all those pathological changes and clinical pictures that are caused by the tubercle bacillus. This name is derived from the Latin *tuberculum*, meaning "little lump" or "nodule," but as we shall see, the formation of nodules is not the only way in which the body reacts against the tubercle bacillus.

Tuberculosis is, then, the sum of all the tissue changes and intoxications, symptoms, and signs that are caused by the tubercle bacillus, regardless of how different the clinical and pathological manifestations may seem on first inspection. We shall show that this seeming complexity is made up of a relatively few building blocks, and that the variegation is but an expression of their many possible combinations. To understand the disease one must have knowledge, then, of the tubercle bacillus, of the manner in which it gains entry into the body, of the characteristics of the host and bacillus that determine the subsequent course of events, and of what this course of events may consist.

A general knowledge of the tubercle bacillus is presupposed in this discussion. For its particular pathogenic—that is, sickness-producing—activities it is sufficient to recall the fact that this microörganism is so well adapted to its parasitic life that a rather delicate balance is established between it and its host, with the result that the bacterial invasion results, as a rule, in particularly chronic reactions.

On first glance the complexity of tuberculosis is confusing. Clinically there does not seem to be any objective similarity between the patient who presents multiple enlarged nodes in the neck draining purulent material (which was called scrofula), the coughing, spitting, feverish, sweating patient, wasting away as if he were being consumed (and hence called consumptive or phthisical), and the acutely ill child with generalized miliary tuberculosis.

Similarly, when one first examines, at the postmortem table and under the microscope, the pathological changes, one is rather bewildered by the seeming complexity. No two specimens ever look quite alike, and extremes are seen that bear no resemblance to each other. As has been pointed out above, the isolation of the tubercle bacillus has made it possible to "unscramble" this puzzle, and to show, by animal experimentation and the demonstration of the bacillus in these various lesions, that all of these seemingly complex pictures are built up of three fundamental tissue reactions.

THREE FUNDAMENTAL REACTIONS

The first type of reaction is degeneration and destruction of cells following the intrusion of the bacilli.

The second fundamental type of reaction is the formation of a nodule

around the bacilli. These nodules, or tubercles (from which, it has been pointed out, the disease obtains its name), grow in size by pushing aside the tissues surrounding them, and are bits of new-formed abnormal tissue.

The third fundamental type of reaction is that of exudation, which means an outpouring of cells and fluid from the blood vessels into the tissue spaces where bacilli have gained access, a reaction characteristic of any inflammation.

The subsequent history of these fundamental lesions is dependent upon a balance between the forces of destruction and the forces of repair. The forces of destruction are the bacilli and the toxic products liberated by the bacilli and the diseased tissue. The forces of repair are the defensive cells of the body—those of the tissues and those of the blood—setting up mechanical barriers, and the protective substances that are present in the blood and tissue fluids.

If the forces of destruction dominate, spreading of the process takes place. The lesions undergo development termed *necrosis*, which means death of tissue, and in tuberculosis this is of a peculiar nature that results in an appearance bearing a resemblance to cheese; hence it is termed *caseation*. And further, this cheesy material may become soft and fluid and be evacuated, leaving behind an ulcer or a cavity.

If the forces of defense and repair dominate, the lesions remain localized, and whatever destruction may have taken place is repaired by the formation of scar tissue (fibrosis) by calcification of caseated foci, and the disappearance (resorption) of inflammatory exudates.

If dissemination has occurred, the process repeats itself wherever material bearing tubercle bacilli is lodged. Nodules or areas of exudation develop, each of which may heal or progress as above described. Thus the total appearance at any stage is composite of these various elements, or more specifically of the two common types of response, the nodule and the exudate, and their various possibilities of evolution—necrosis, cheesy degeneration, liquefaction, ulceration, calcification, fibrosis.

HOW DO SYMPTOMS ARISE?

There are two general ways in which these lesions may give rise to symptoms. The first is by the mechanical irritation of their presence, in which case symptoms depend upon the accidents of localization. For example, a deposition of bacilli on one of the vocal cords followed by the development of a nodule at that point would manifest itself by hoarseness and perhaps pain in the throat. A similar lesion in the brain might give rise to neurological signs. A lesion along a bronchus might by irritation initiate those reflexes that result in cough. Similarly, such lesions in the large bowel would reflexly set up spasms that would manifest themselves by abdominal pain, nausea, vomiting, and other functional disturbances. A lesion involving the wall of a blood vessel in the lung would, if it destroyed that wall, result in hemoptysis (spitting of blood). These illustrations might be multiplied endlessly, but the point is evident.

Another way by which symptoms arise is by absorption of noxious materials from these lesions, either from the bacilli themselves or from the dead and dying tissues. These noxious substances are distributed through the body and give rise to general symptoms of ill health, such as fever, rapid pulse, loss of weight, fatigue, and anemia.

Up to this point we have discussed the elements of the response of a host to the presence of the tubercle bacillus, and the possible evolutions of these fundamental tissue reactions as they might occur anywhere in the body. In studying patients with tuberculosis, however, it is noted that the sequence of events from infection to healing or

death tends to follow certain *patterns*.

This is probably because in every period of history, every epoch of culture, there are certain group practices of housing, nutrition, social and family relationships, modes of living, eating, sleeping, and working that determine the most usual way in which persons encounter the tubercle bacillus, the frequence of such encounters, and the individual's state of health and general resistance.

This is well brought out by a consideration of the manner in which tubercle bacilli gain access to the body. Wherever the bacilli are first introduced, lesions are produced. In civilizations where eating with the fingers from a common bowl is common practice—for example, the American Indians—infection produced by introducing the bacillus via the fingers to the mouth is frequent, and the result is massive infection of the lymphatic structures of the neck as part of the initial lesion. In other communities where raw milk is drunk, and where the herds of cattle are infected with tuberculosis, the portal of entry is commonly the intestinal tract. However, in our present manner of life in the United States, by far the commonest mode of entry is by *inhalation*. Persons who have pulmonary tuberculosis cough spray the air with droplets of sputum containing the bacilli, and these are inhaled by other persons. Hence arises the great public health problem of the control of sputum and of careless coughing.

PRIMARY INFECTION

Since the commonest mode of infection is by inhalation, the commonest site of first infection is in the lung. One would therefore expect to see the earliest lesions in those parts of the lungs which are best aerated, and this is indeed the case. When the bacilli are thus deposited in these portions of the lungs, a small area of exudation (that is, pneumonia) results as described above. Bacilli are here picked up by certain cells of the body and carried in them through the lymphatic channels to the lymph nodes at the root of the lung, where lesions are set up.

It is this combination of pulmonary lesion at the periphery of the lung where the bacilli are first deposited and lesions in the lymph nodes at the roots or hila which is called the *primary complex* and which presents in any stage of its development a quite characteristic lesion, different in important particulars from any later tuberculous lesions. Formerly, since most persons in the ordinary routine of life became infected in childhood or early adolescence, the active phase of these lesions was seen mostly in the young, and was therefore called the *childhood type* of tuberculosis. But now that many persons do not become infected until reaching adult life, more and more of these lesions are seen in older persons, and hence the term *primary infection or complex* is to be preferred.

In some instances these primary lesions progress—that is, the forces of destruction overwhelm those of defense and repair—and the bacilli become disseminated. These disseminations take place by all possible routes: by contiguity, within the bronchi, by the lymphatics, and by the blood stream. If massive amounts of tubercle bacilli enter the blood stream, generalized miliary tuberculosis develops. In this form of tuberculosis, millet-seed-sized lesions are scattered throughout most organs of the body. If the coverings of the brain are involved in this process, tuberculous meningitis appears, which occurs more frequently soon after the first infection than at any other stage of the disease. However, the vast majority of primary lesions heal by fibrotic encapsulation and very commonly by the deposition of calcium. It is to be further noted that during the developments above outlined, there may be either no symptoms or signs—nor even

detectable x-ray changes—or there may be symptoms and signs of grave disease.

The fact that an individual has been infected with tubercle bacilli by inhalation, and that he harbors more or less healed lesions of that encounter, bears certain quite important implications concerning future events. In the first place, although the lesions may be healed, they may still and probably often do harbor living tubercle bacilli for an indefinite period of time, although these bacilli are imprisoned, so to speak. Their very presence is in the nature of a sword of Damocles, an ever-constant threat to health if changed conditions should allow their release. This aspect of the primary infection may be looked upon as a debit item in one's balance with his environment.

On the other hand, the fact that the body has reacted once to the tubercle bacillus may be looked upon as an asset, for, to use an analogy that should not be interpreted too literally, the memory of that encounter conditions all future reactions to tubercle bacilli. Henceforth the defensive forces of the body will be mobilized more quickly and more effectively when and if bacilli again gain entrance to the host, or when and if the bacilli dormant in the healed first lesions gain exit. This changed reaction is called *allergy*. Concomitantly with the appearance of this changed speed of reaction, there is some measure of immunity, a greater resistance, which, although far from being absolute, is of definite moment, provided the dosage of reinfection is not so massive as to overwhelm the limited powers of defense. The presence of this changed reaction, this allergy, can be very easily demonstrated in any individual by injecting into or beneath the skin *tuberculin*, a product of the tubercle bacillus, which evokes rapid inflammatory responses only in a body that has been previously infected.

After the primary infection has healed, as it does in most instances, the vast majority of persons will uneventfully live out their life span without further misfortune attributable to tuberculosis. But a certain proportion of these, after a latent period, will develop new lesions and the symptoms and signs of active disease. The most important controversy regarding the development of reinfection tuberculosis is concerned with the question as to whether these reinfecting bacilli are introduced from the outside or whether they are bacilli which, hitherto dormant in the healed primary lesions, have for one reason or another been disseminated afresh. There is no question that both of these events are possible, but it is a matter of considerable dispute which occurs most frequently.

FACTORS FAVORING REINFECTION

Disregarding for the moment this question of the derivation of the reinfecting bacilli, what calls for explanation is the fact that while most persons with a primary infection do not develop progressive disease, some do. The factors responsible for the development of the disease—the pathogenetic factors—can be studied by inquiring into the circumstances surrounding the unfortunate minority. By statistical studies it is found that persons living in contact with patients with open tuberculosis are more frequently affected than persons without such contacts; that the tuberculosis mortality rate is almost ten times higher in the lowest socio-economic group than among the rich, and from four to six times higher in Negroes than in whites; that in certain age-groups women are much more susceptible than men; and that certain age-groups are much more in danger than others. This brief and incomplete enumeration shows at once that exposure to tuberculosis is only *one* of the manifold features favoring the development of reinfection tuberculosis and that socio-economic conditions, race, sex, and age must be considered as significant pathogenetic factors.

In this connection it should be explained that we know from animal experiments that animals with a primary infection develop an increased resistance toward tuberculosis which is, however, effective only if reinfection is produced by very small amounts of tubercle bacilli. If we try to translate this into human conditions it is suggestive to assume that under ordinary conditions of life—that is, reasonable health and not more than occasional minimal reinfections—the primary infection protects against such minimal infections. Single massive infections from the outside are impossible for anatomical and physiological reasons. Massive infection from the outside can only mean frequently repeated infections (such as are caused by domiciliary contact). However, a massive reinfection from the inside is always possible if the bacilli from the primary lesions are released from the enclosure of their encapsulation.

It appears likely, therefore, that reinfection tuberculosis is prone to develop (1) when the forces of defense are broken down by physiological stresses, of which malnutrition and fatigue are probably important ones (2) when the increased resistance created by the first infection is overwhelmed by massive reinfection, that is, by residential contact with an open case of tuberculosis or by the breaking loose of the bacilli from previous foci in the body. It is not possible with our present knowledge to say whether reinfection from within or from without is more frequently responsible for the development of pulmonary tuberculosis in the adult, but it is most important to emphasize that living and working conditions, race, sex, and age are highly significant features in the fight of the body against tubercle bacilli, regardless of where they come from.

The first reinfection lesion that customarily appears in the lungs is a small area of pneumonia, usually less than three centimeters in diameter, most frequently seen in the midlung field or just below the clavicles. These new lesions are always quite unstable; that is, they quickly heal (again by scarring or disappearing) or they progress. If they do progress, there is this difference from the progression of the primary infection lesions—that progression occurs almost entirely by contiguous spread or by dissemination through the bronchi. A common development of these lesions is the formation of a cavity. As soon as a cavity is established the patient has sputum containing tubercle bacilli. By means of the sputum, bacilli are readily spread through the bronchi, causing new foci of disease.

Progressive reinfection tuberculosis of the lungs is the type commonly seen, and since it was previously seen more often in adults, it was termed *adult type* tuberculosis in contradistinction to *childhood type,* as before explained. But as is now evident, since the factor that conditions this form of tuberculosis is that it is a reinfection—and not the age at which it occurs—it is better termed *reinfection tuberculosis.*

Tuberculosis is a very old disease, probably coexistent with man. The earliest recognizable descriptions of it extend perhaps to 2000 B.C. Throughout these many ages it has undoubtedly waxed and waned many times as an important determining factor of man's life, as man's habits and customs of life changed and as varying socio-economical factors influenced his manner of living. For our present age, the peak of this destructive disease was apparently reached shortly before 1850. Since that time its total destructiveness has continuously waned, but it still remains the most important cause of death in young and middle-adult life. It is, therefore, one of the most important duties of public health work to continue and intensify all efforts toward its control.

EDITOR'S NOTE: This is the third in a series of articles on various phases of tuberculosis.

"Our Children"

By ANNA C. GRING, R.N.
Assistant to National Director, Public Health Nursing and Home Hygiene and Care of the Sick, American National Red Cross

A visitor describes her impressions of a parents' club in which the members freely discuss their own problems

SLOWLY the mothers and fathers belonging to the parents' club at East Harlem Nursing and Health Service assembled. The president of the group, together with some of the club members and a few of the nurses from the staff formed the receiving line. No, the nurses did not conduct the meeting. They did not even wear uniforms, but were there as assistant hostesses to the parents. Several nationalities, totaling approximately fifty people, were represented—including Italians, Puerto Ricans, native-born Americans of Irish and Italian extraction, and those from families with several generations of American citizenship.

The president, a stocky, blond, happy-appearing mother of Irish descent, called the meeting to order with a brief, informal speech introducing the leader. She emphasized the fact that he is the father of three children—rather than his qualification as a specialist in parent education. She commented that it was fortunate the fathers and mothers attended the same meeting because they could compare notes and discuss it afterwards.

Acknowledging the introduction, the leader asked the group whether they wished the discussion to start with questions from the floor or from those sent him in advance. They decided to begin with questions from the group, and one was immediately forthcoming: "What should we do when our 16- and 17-year-old daughters want to go out on dates and where should we allow them to go?" From this problem developed a discussion of sex education. An Italian father who had difficulty in expressing himself in English thought that many of the problems of adolescence would be prevented if parents would answer all the child's questions truthfully. He said, "Most of us teach something about religion, and parents could answer these questions according to the teachings of their church." This father has five small children. His wife is unable to speak any English. He is trying to teach her with the help of the radio program from the WNYC Municipal Radio Broadcasting Station. He attends the clubs regularly, and before the meeting he told the visitor that he hoped to bring up the question of jealousy among the children since he does not know how to deal with it. He is also interested in teaching wrestling to the fathers during their social hour as he thinks it is good sport.

"WHERE DO BABIES COME FROM?"

Several mothers disagreed regarding the time when sex information should be given. One petite, olive-skinned Puerto Rican mother said that when the child asks, "Where do babies come from?"—one should say "from the mother." When her son, aged twelve, asked how the baby got out of the mother she did not know how to answer, but her husband explained. After the meeting the visitor inquired of this mother how they answered their child's question. She said her boy asked whether the baby came

out of the rectum, and her husband said, "No, but there's a place near the rectum in the mother that the baby comes from." So they decided to buy white rats and the whole family watched for the babies. Sonny fortunately was at home when the rats arrived and they watched the birth. When the female ate the placenta, Sonny asked "Mother, did you know that?" And she answered, "No, I didn't." Since the parents have answered their children's questions frankly, their curiosity seems satisfied and questions relating to sex and reproduction are few.

The methods of answering these questions varied from, "I'll tell you when you're older," to giving direct answers to the inquiries. But the general conclusion seemed to be that the parents have a responsibility for answering questions as they arise and that frankness in answering will prevent children of sixteen and seventeen years of age from making irreparable mistakes.

After this digression from the initial question, the matter of dates for the 17-year-olds was again discussed. Some allowed movies and prohibited dances; others allowed both but wanted to meet the "boy friend." Again the conclusion was reached that honesty and fairness on the part of the parents from infancy and through childhood will develop these qualities in the children, and the solution of the question of dates will be mutually agreed upon.

The leader called attention to the fact that sex information alone will not prevent difficulties, but that intelligent understanding, honesty, and fairness all along the way will develop characteristics such as good judgment and respect for the other person.

THE NEW BABY

"What shall we tell our small children when a new baby is coming?" asked one parent. Another added, "Sometimes the older child is jealous of the new baby—what shall we do?"

"Tell your children and let them help to prepare the clothes and supplies for the baby's care," said other parents.

"But," said one mother, "even with careful preparation the baby was about two months old before Tommy's jealousy disappeared. About that time he began to feel that he had to help take care of the baby and he was different."

TELLING SAD THINGS TO A CHILD

"Shall we tell little children anything sad," asked one mother—"as when someone dies in the family?"

Another gave her experience: "A few weeks ago my little girl went along with me when I was shopping and a man was killed right in front of us. I explained that he hadn't watched the traffic light. For a few days she asked me questions and I knew she remembered what that dead man looked like, the same as I did. But after a while she seemed to forget it."

"My mother died when I was very young," said one mother, "but I remember how she looked when she was dead, and I wouldn't let Tommy see my father when he died. He keeps asking questions, but I just tell him that Grandfather has gone away for a long time."

The consensus seemed to be that children could be told sad things without making them gruesome and that sadness had to be accepted as a part of life.

SHOWING OFF

The president of the club raised a problem: "I think my children are as well behaved as most. They're pretty nice children, but *why*, when I have company, do they insist on showing off and doing things they never think of doing ordinarily? I ask them kindly and tactfully to play in another room and they pay no attention to me. We talk and talk about 'children's rights,' but don't the parents have some rights, too?"

"I think we're worried when we have company," said one parent, "because

we're afraid of what the company will think of us and the child knows it and then shows off."

Another suggested, "If you don't pay any attention to them they get tired of it and return to their own play."

These are a few observations of a parents' conference in which the nurse's ideas of what parents needed were not superimposed, but the parents discussed their own problems. Several thoughts occurred to the visitor as she listened to this interesting exchange of ideas and problems:

1. Is it possible that this group is a part of the so-called underprivileged section of New York City? Certainly their observations and philosophy would do credit to a group of college graduates.

2. Are we really in the process of accomplishing our ultimate goal in teaching in public health nursing—the goal described by Grace L. Anderson: "Is it (our goal) not to help parents formulate their own problems and learn how to meet them, to make them curious about some of the things that are going on around them"?*

3. If this is our goal, is not the nurse's preparation for the job fundamental to its accomplishment?

4. It seems obvious that a discussion by the group of its felt needs is much more effective in the promotion of health and the prevention of illness than the pouring-in method which is so often used in parents' conferences.

5. The success of this discussion seems to the visitor to be due to: (1) the skill of the leader (2) the type of educational methods used by the East Harlem Nursing and Health Service, in conferences, clubs, and home visits.

. . . . . .

Last but not least, refreshments were prepared by the mothers and served by the fathers, and "a good time was had by all," including the visitor.

*New York City Health Department, *Our Nurses*. October 1937.

A. Tennyson Beals

The fathers and mothers attend the same meeting

The Staff Nurse Analyzes Her Own Work

By MRS. LUELLA LEWIS, R.N.
Staff Nurse, Visiting Nurse Association, Detroit, Michigan

How can today's public health nurse keep pace with rapid developments and changing needs? A staff nurse urges self-analysis as the antidote for complacency

PUBLIC HEALTH NURSING has developed so rapidly in recent years that we need to analyze our work to see what we have to do to keep pace with these developments. This article attempts to analyze the urban nurse's work, and the skills which she uses.

Probably the very first requisite for successful public health nursing is that one should like people—all kinds of people. A nurse cannot gain the confidence of a family if she is intolerant of their customs, race, or religion—unless she is an excellent actress! And if it *is* necessary for her to act a part, she will be unhappy in her work, whether it is successful or unsuccessful. In the hospital she may have for her morning assignment one patient of a racial or national type toward which she has some prejudice, and she can put up with that, since he will take up only a small portion of her time. In the public health field she has to deal not only with the patient, but with the entire family or perhaps with a whole community of this type. Therefore, it would seem that liking people is just as much a part of our work as teaching or bedside care.

WHAT DO WE NEED TO KNOW?

In any type of public health work a fundamental body of knowledge is obviously another essential. As our work expands, more demands are constantly being made on the nurse; and further study is ever essential. First, there is the knowledge acquired in the school of nursing regarding diseases—symptoms, etiology, and mode of treatment. Besides this, the public health nurse today is expected to know how to prevent disease, especially communicable disease, and how to teach the public to stay well. Other phases of work in which she is required to have a well founded background of knowledge are: personal hygiene for adults and children, dental hygiene, nutrition, first aid and how to prevent accidents in the home, child guidance and problems of juvenile delinquency, mental hygiene in all of its various applications, social hygiene, and social and economic problems of the community. This is a big order, but with constant study and with practice in the application of facts learned, one can minimize the complexities of the task.

PLANNING AND MANAGEMENT

Assuming that she has a liking for people and this basic knowledge, the public health nurse finds her work falling into five general divisions. First, part of her time must be given to planning and management. This is tremendously important because of the responsibility that is placed on the field nurse to take care of her own district, with considerably less supervision than she would have in the hospital.

The hospital nurse is able to see all of her patients within a few minutes. She knows, for example, that Mrs. Allen is to go to the operating room for surgery at 10:00 o'clock, that Mrs.

Brown is to go home at 2:30 in the afternoon, and that Mrs. Cross is a new patient who came in at 1:00 a. m. in a comatose state. Her entire picture is before her with specific orders for each patient. And if she needs further orders, there is usually an interne close at hand to answer her call.

How different this is from our situation! We constantly make new calls with no idea what physical conditions we will have to meet, or what mental state the entire family will be in when we arrive. Once we are in the home, it is sometimes several hours before the doctor can be reached, or perhaps the family do not even want a doctor called. The nurse does not have a supervisor just outside the door to consult; neither has she any specific orders to follow on first visits in many cases. Her supervisor depends on her to use her own best judgment, and care for the situation in the best way she knows how to do. I do not mean by this that we cannot call upon our supervisors for advice, but they are not so conveniently located as are those in the hospital. Instead of being responsible for thirty or forty patients on a floor, they may have a hundred or more in a large territory, and they do not have time to make their nurses' decisions for them. Moreover, there are many public health nurses who have no supervisors and who must accept the full responsibility themselves.

Another phase of the planning and management of the work is the neat, orderly completion of each unit of work, done with a conservation of time and energy and with an appearance of competence, leaving each piece of work a *finished* product.

Successful planning and management are dependent upon at least four qualities in the nurse: power of observation, good judgment, ingenuity, and initiative. To be more specific, she needs the ability to see the entire situation from all angles; judgment to decide the relative importance of its various aspects; ingenuity to formulate—or help the family formulate—a plan of treatment; and initiative to carry out her plans and assume responsibility for them. She is called upon not only to analyze the conditions of the patient, but to study the entire family and judge their ability to cope with the situation. She has to decide whether her treatment will be preventive or corrective and which part of the situation is the most emergent.

BEDSIDE CARE

In those organizations which do bedside nursing, it is a second and a very important phase of our work. An individual who is acutely ill naturally wants the best nursing care available and we should be able to offer it. What, then, are the requisites of fine nursing care? First of all, the nurse must have a clear understanding of the fundamental principles underlying treatments and techniques; and second, she must have an appreciation of the importance of the little details that make for comfort.

Carrying out the doctor's orders or the procedures of the organization by mere imitation rather than with intelligent understanding is too likely to endanger the patient. The nurse cannot imitate a technique and be always sure that she is 100 percent right, unless she knows why it is done a certain way. Without an understanding of good technique the nurse cannot safely adapt her methods to the individual situation lest her adaptation will not be founded on sound principles. Furthermore, if the nurse has this sense of good technique she will never be found placing much handled street guides or other soiled literature, hair combs, nail files, or other such items in the supposedly "clean" section of her bag. A nurse guilty of such irregularities would no doubt be found negligent in other applications of her techniques.

As for an appreciation of details—a nurse who does not know the discomfort of being partially dried during a bath, or the refreshed feeling of having a pillow turned and fluffed up, all too frequently does not render her patients complete satisfaction.

SKILLFUL INTERVIEWING

Interviewing is a third division of the nurse's work. This is a phase of our work used daily in contacts with patients, their relatives and friends, physicians, social workers, supervisors and consultants in special lines—such as nutritionists, mental hygienists, and physical therapists—and others. In dealing with patients the nurse must be a sympathetic and intelligent listener, bearing in mind that their feeling and reactions are based consciously or unconsciously on past experiences. Another essential is that the interview should have a purpose, and the conversation will need guidance to obtain the desired information. This requires a skill that grows only with constructive practice and study.

CLERICAL WORK

Fourth, there is clerical work, which in all its aspects continues to be a bugaboo to many nurses. All too many of us dislike it, partly because we are not able to do it adequately and partly because we try to make so much work of it. What is required in the way of skills in order to do a really fine piece of clerical work? First, skill in interviewing is needed, in order to be able to get the required information. Then, once the information is obtained, judgment is necessary to discern what part of it is essential in the history. After this, we need an adequate vocabulary to express in writing a clear picture of the case, complete yet concise, avoiding lengthy records with repetition and unnecessary data. Finally, neatness is always a requisite in any nursing work and records are no exception.

EFFECTIVE TEACHING

The fifth type of skill which we are called upon to use is teaching. What an important part this plays in our daily work! First of all, the nurse needs to recognize teaching opportunities. Once she has recognized them, she should have the correct information to divulge. If she does have the information, there is still the important matter of effective presentation. Too often we *advise* rather than *teach*.

We can tell the mother of five children including a new baby, "Now of course Mrs. Jones, you need lots of rest. Lie down every day a while, take time out for a good long relaxation period." Mrs. Jones will probably say after we leave that we don't know anything about caring for a home or raising a family or how much work it takes. Rather than giving this general advice, we should assist the mother to establish a routine that will allow her a period of rest, explaining *why* rest is essential, giving her actual facts—not expecting her to accept what we say because we have said it.

The nurse, then, should have some knowledge of the principles of teaching and teaching methods, an understanding of human psychology, and a broad and tolerant viewpoint at all times in order to be a successful teacher.

METHODS OF SELF-IMPROVEMENT

Having thus enumerated some of the things that are required of the public health nurse in the way of activities and skills, let us consider how she can go about improving her abilities and thus improve the standards of public health nursing in general. Five methods are suggested here which are available, in some part at least, to all nurses. They are staff education, academic study, use of supervisors, the stimulus of a student program, and self-analysis. The extent to which the nurse avails herself of any of these depends on her own initiative.

STAFF EDUCATION

The first method, staff education, is in part the responsibility of the individual agency. It is a much discussed method of education at the moment. Nearly every issue of PUBLIC HEALTH NURSING last year contained at least one article on this subject. Various plans for formulating programs have been suggested, but in the final analysis each organization should develop its own program along the lines most suited to and desired by its own staff. The true success of such a program depends on each individual staff member and her active participation both in planning and in carrying out the program.

There are many types of programs and a wide variety of subject matter is available. The use of outside professional speakers and specialists in various lines related to public health is always popular, although for the staff members themselves to conduct the programs provides a splendid opportunity for their own development. Small group conferences, conducted by members of the staff, are found to be very beneficial. Programs may include case discussions, demonstrations of techniques, book reviews, studies of nationalities present in the territory covered by the group, economic situations, and community resources such as social agencies, nursery schools, and clinics. The "How Would You Answer These" section of PUBLIC HEALTH NURSING might form a stimulating part of the year's program. The point to emphasize in this activity is the staff nurse's active participation.

ACADEMIC STUDY

More dependent on the nurse's own initiative is the academic work in any form which she may undertake. Of greatest significance are the public health nursing courses. Any nurse entering the field without having completed a curriculum in public health nursing should immediately make plans for taking it, thus acquiring a knowledge of the principles of public health nursing together with accompanying field experience. A few agencies are so located that their nurses can arrange to work during the days and attend night classes. This arrangement is most helpful to the nurse who is financially unable to attend college on a full-time basis. However, a very frugal individual may be able to save money in order to enter a regular college curriculum and will find it greatly to her advantage to do so.

Another method of securing academic education is through the extension courses and correspondence courses offered by many universities and colleges.

Aside from prescribed courses of study there are also many possibilities for informal study left to the individual's choice. Personal reading may include both professional and nonprofessional magazines and books which will help the nurse with her work or broaden her general background especially in social and economic fields. Remembering that "All work and no play makes Jack a dull boy," some literature of a lighter nature should be included. Attendance at lectures, institutes and conventions offering help on any subjects related to the public health field broadens the outlook and opens up new fields of interest.

What are some of these fields in which the nurse of today should interest herself? It takes only a glance through current professional magazines to see what the trends of thought are. Nutrition is one subject that we are finding applicable both in the homes and schools. The nurse should be equipped with at least the fundamentals of normal nutrition for all ages and should have some knowledge of modern diet therapy. There is also a definite need for some knowledge of food costs and budgeting.

The study of the handicapped child is becoming more and more important in

the public health nursing field. The need for nurses well trained in this line is increasing. However, we are found lacking in a knowledge of even the bare essentials, such as the recognition of defects and the causes and treatments of crippling conditions.

The fields of mental hygiene and educational psychology offer another challenge. In addition to the study of elementary psychology and of psychiatry, the nurse is interested in such subjects as child guidance, the relation of abnormal physical conditions to emotional stability, juvenile delinquency, and emotional disturbances of pregnancy.

The need for sex education in the home and school is becoming a recognized fact. Nurses are being confronted with questions from anxious parents and from teachers—questions that they are not adequately equipped to answer.

Other important phases of public health programs today are social hygiene, the prevention of home hazards, the coördination of school health with the educational program, and public health administration.

USE OF SUPERVISORS

There is another opportunity for improving our skills, that for the most of us is very accessible, and that is the use of supervisors. All too many nurses have, consciously or unconsciously, a fear or dread of supervisors. This attitude is often carried over from the close militaristic supervision of the old-time school of nursing. Until the nurse learns from experience with constructive and helpful supervision that the supervisor's function is one of an advisor and helper, she will either reject or dread criticism instead of seeking it. Difficult problems—such as questions regarding management, treatment, and disposition of cases, and personality difficulties—may be taken up with the supervisor. Her broader education and experience more ably fit her to deal with perplexing situations and the nurse should make the most of this opportunity. The average supervisor would much prefer that the nurse invite her into the field, rather than having to tell the nurse every so often that she will accompany her on a certain day. If one is fortunate enough to be on a staff where there are special supervisors in physical or occupational therapy, nutrition, mental hygiene and maternity work, they offer a splendid chance for the nurse to get additional advice and information in these lines applicable to specific cases and situations.

STIMULUS OF STUDENT PROGRAM

Organizations having a student program have another educational opportunity to offer their nurses. The chance for the senior nurses to take students into the field for demonstration, the opportunity to discuss these visits with the student and with the field teacher, the stimulating atmosphere aroused by younger and perhaps more enthusiastic nurses—all open a wide field wherein the nurse can increase her knowledge and improve her skills.

SELF-ANALYSIS

There is nothing more detrimental to an agency's standards than for the nurses to develop a pernicious complacency about their work. Many persons let a self-satisfied and self-sufficient feeling grow on them after a few years of experience, a feeling that all is known and that no improvement is necessary. However, there is a way for the nurse to avoid this danger and that is through self-analysis—an analysis of her own attitudes, her appearance, and the quantity and quality of her work.

As to her attitude—a nurse should be able to discover very soon whether or not her work is enjoyable. If not, some adjustment can usually be made either on the part of the nurse or the agency, to make the work more satisfactory. If there are prejudices that make contacts

difficult, it may be that they are born of ignorance. Especially is this so in relations with certain races and nationalities. A study of customs, traditions and creeds may prove these prejudices to be only misconceptions. Personality maladjustments of the nurse can often be corrected through a study of psychology and of normal emotional developments, or by consultation with the supervisor—or if possible, with a mental hygienist. Emotional stability, a well integrated personality, and a lack of prejudices are all essential in order to receive satisfaction and attain success in one's work.

An occasional analysis of our appearance is helpful to keep us up to the standards expected of nurses by the public that sees us during the day.

The analysis by the nurse of the quality and the quantity of her own work should not be a spasmodic, time-consuming affair. Rather, it should be a frequent study of the kind of work she is doing, covering the quality of her planning and management, techniques and treatments, records, interviews, and teaching organization. She should ask herself whether she is keeping her health instructions up to date with the most recent knowledge; whether the laws of learning are being applied; and whether the available community resources are being intelligently used. This self-appraisal can be made by analyzing individual case records, by studying the entire work of the district as to the amount of various illnesses, and whether the case load is growing or diminishing, and through the aid of conferences with supervisors.

Presented at the N.O.P.H.N. Round Table for Urban Staff Nurses, Biennial Convention, Kansas City, Missouri, April 27, 1938.

How Would You Answer These?

Here are some questions which frequently arise in connection with maternity nursing. More than a superficial knowledge is necessary in order to answer them adequately. The references below will assist you in studying the subject. Some suggested answers will be published in August. Won't you send *your* answers—together with any questions or problems you may have on maternal welfare—to the Maternity Center Association, 1 East 57 Street, New York, N. Y.

1. What are varicose veins, and what causes them?

2. What changes occur during pregnancy which tend to increase the discomfort from varicosities?

3. What suggestions can the nurse give to the pregnant mother to prevent or relieve distress from varicosities?

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N.O.P.H.N. Model 1936-1938*

By DOROTHY DEMING, R.N.
General Director, National Organization for Public Health Nursing

The General Director reports to the membership on the work of the N.O.P.H.N. during the past biennium

EVERY TWO YEARS the General Director of the National Organization for Public Health Nursing has the pleasant responsibility of reporting to you—our membership—the progress made in the biennial period. In 1936 I outlined what I saw then as the special needs of our national program. In this report I want to summarize as briefly as possible what we have accomplished since 1936, remembering that the Organization is the sum total of the Board, Sections, Committees, and Staff—all made possible through you, its members. You elect our Board, you serve on our Sections and our Committees, and your support makes possible our staff program. I hope that as you read the reports of our Sections and Committees published in the April number of *Listening In* you will think of yourself as a member of each, identify yourself for a moment with the work of each, and see if what you find there is good.

The staff is the executive department for our Sections and Committees. Our work has three main purposes: The setting of standards, the interpretation of standards, and the promotion of standards. And since this is a partnership in which we are engaged, I can say enthusiastically that I think these last two years have been productive and progressive. Let us turn to the record:

1. We have set standards by publishing:**

The "Functions in Public Health Nursing"—What we expect the public health nurse to do

The revised edition of the *Board Members' Manual*—what we expect a board member to do

A study of personnel practices in official agencies with appropriate recommendations

A handbook of "Suggestions for Statistical Reporting and Cost Computation in Public Health Nursing"

Bookkeeping forms for cost accounting

A statement of "Minimum Qualifications for Nurses Appointed to School Nursing" to accompany the "Minimum Qualifications" for the general field

Recommendations for setting standards for affiliation in public health nursing for student nurses

Recommendations for preparing public health nurses for the orthopedic field

To assist us in establishing standards, we have created two special advisory councils—a Council on Maternity and Child Health and a Council on Orthopedic Nursing. And by enlarging our Magazine Committee to a Publications Committee, we plan to seek assistance in the large problem of supplying needed printed material in the public health nursing field, as well as advice on our own editorial policies.

2. The interpretation of our standards, we have pursued with vigor and a satisfying record.

Foremost as a job in interpretation of

*Report of the General Director, presented at the N.O.P.H.N. Business Meeting, Biennial Convention, Kansas City, Missouri, April 26, 1938.

**Information regarding any of these publications or activities may be secured from the National Organization for Public Health Nursing, 50 West 50 Street, New York, New York.

our own N.O.P.H.N. stands the report of the Committee to Study the Functions of the N.O.P.H.N. which appeared in the April number of the magazine. For the general public, the high-water mark of interpretation came through our Silver Jubilee celebration in 1937. You—our members—made possible the widest newspaper publicity in any given year that public health nursing has ever had. You gave us 37 celebrations in 25 states. You helped in giving public health nursing a place in four popular magazines, and quite directly this wider understanding of our goals and service brought us the largest individual and agency membership in our history.

Interpretative also are our loan folders, our new catalogue of pictures and cuts, our reading lists, our posters, the booklet called *The Public Health Nurse,* prepared with our help by the Central Hanover Bank and Trust Company of New York for nonprofessional reading.

3. And, now, promotion of standards: In field, in office, through letters, through talks, through studies—it is a continuous, never-ending process which, like interpretation, is the heart and soul of our job. For what good are standards if they lie on a dusty shelf? They must be taken down and put to work. So, we have put them to work:

In field trips that have covered all but seven states in the Union and 357 communities in the last two years

In talks that have reached 15,000 people—not counting radio addresses over 6 broadcasts, two of them nationwide

In community studies in ten localities

In helping to establish two new visiting nurse associations

In the endorsement of five new courses in public health nursing which meet N.O.P.H.N. standards, bringing our total to 19 courses

In lectures to ten student audiences connected with endorsed courses

In six special consultant visits to help on records and statistics (Unfortunately, this service was available for only two months)

In twenty institutes and round tables on board and committee member problems

In attendance at 16 national conferences of other health and social agencies

In service on twelve national committees

In establishing a clearing-house for public health nursing studies at the N.O.P.H.N.

In continuing to participate in the Joint Committee on Community Nursing Service

In studying and analyzing our problems of placement service

In work on annuities, pension and insurance plans for nursing staffs

In continuing and voting definitely to continue PUBLIC HEALTH NURSING magazine

In developing the richest supply of reading and source material we have had since 1929 in the field of school nursing

In offering more field service to school nurses

In developing relationships with the National Education Association, American Association of School Health, National Congress of Parents and Teachers, General Federation of Women's Clubs, and National Tuberculosis Association

In joining with the American Public Health Association for the first time in a joint convention in 1937

And not least—but when have I had a chance to mention it before!—we have seen the embryo development of N.O.P.H.N. consultation service to nurses in industry and a section planned for them in the magazine to start in the fall of 1938.

All these things we have done.
I hope you will find the record good.
I hope you will help to make it better by 1940.

Summaries of Round Tables

THE DISCUSSIONS at the thirteen Round Tables which were held simultaneously on April 27, 1938, at the Biennial Convention in Kansas City, Missouri, are summarized here in response to many requests for their publication. It is hoped that the high points of the discussions will be of interest and value both to those who attended the convention—but who found it hard to choose between several Round Tables—and to those who could not be at the convention. Also, they may be helpful in pulling together the threads of the discussions for delegates and others who will bring back reports to their agencies and communities. Several of the formal papers which were prepared for Round Tables will be published or abstracted in subsequent issues of the magazine.

ADMINISTRATORS OF AGENCIES WITH STAFFS OVER TWENTY

The Round Table for the directors of organizations with staffs of twenty or over, under the leadership of Mrs. Gertrude Lyons, Director, St. Paul Family Nursing Service (Minn.), concentrated upon the cost per visit and the relation of the cost to the content of the visit. A paper on this subject read by Helen Stevens, Director, Public Health Nursing Association, Pittsburgh, Pennsylvania, was followed by discussion started by Winifred Fitzpatrick, Director, Providence District Nursing Association, R. I.

It was brought out that logically a costlier visit ought to be a better visit, but that no proof has so far been obtained that such is the case. In relation to cost, specialized and generalized supervision were discussed. It was accepted that specialized supervision has increased the cost, but no positive proof has been forthcoming that the content of the visit has been enriched.

It would seem obvious that the five-day week will increase the cost per visit. Whether it will affect the content of the visit will have to be determined later when it has been studied over a longer period of time and when the visits have been analyzed more carefully. The five-day week is admittedly an interesting and worthwhile social experiment.

It was brought out that the cost per visit should be kept within the pocketbook of the locality served.

The group was informed that the Metropolitan Life Insurance Company is making a study of methods to evaluate a nursing visit. Their findings will be made available to all organizations through the N.O.P.H.N.

ADMINISTRATORS OF AGENCIES WITH STAFFS UNDER TWENTY

Community relationships between different agencies were discussed under the leadership of Arline R. Mansfield, Director, Visiting Nurse Association, Easton, Pennsylvania.

Several important points in the development of coöperation between a health agency and other social agencies were brought out by Bertha Harvey, Superintendent, Visiting Nurse Association, Davenport, Iowa: the necessity for knowing the services and policies of other community agencies; the need to prevent overlapping; the value of having an organization of public health nurses in a community for the exchange of ideas on problems and for social meetings; the value of interpretation of the services to the community through the newspapers—preferably

through acquaintance with a reporter on each paper; and the usefulness of a coöperative case study in regard to families in which various agencies are interested.

The use of agency boards to develop coöperation was discussed by Adah Hershey, Director, Public Health Nursing Association, Des Moines, Iowa, who emphasized the need for education of the board of directors as fundamental to coöperation. She said that understanding by the board members of the work and the limitations of their own agency is necessary to effective coöperation with others; that the board should have a community spirit which makes them want to plan what is best for their home town; that they should take every opportunity to secure an understanding with other agencies; that guidance and leadership on the part of the director of nurses are essential; that all should work together to coördinate the whole community program, which is the only thing that counts after all; and that effective coöperation cannot be attained in a short time—it is the product of years of work.

The methods used in developing a spirit and technique of coöperation among a group of Negro nurses were described by Mary Friez, Supervisor, Child Hygiene, Department of Health, Memphis, Tennessee. Through a council of staff members and a staff education program the nurses have analyzed their case histories, studying their own part and the part of others in relation to the problems of the families, and learning thus to coördinate their efforts effectively.

An interesting plan for coöperation of all the various social and health agencies in a community was outlined by Mrs. Winifred Scholer, Assistant Superintendent, Kansas City (Missouri) Provident Association, and Chairman of the Kansas City Chapter of the American Association of Social Workers. The agencies in this city have developed a professional case conference whose members come together on call to discuss problems of a particular family in which various agencies are interested. Mrs. Scholer explained that the conference is not an open discussion for interpretive purposes, but is entirely on a professional level, for the confidential discussion of problems. A standing group of about fifteen people forms the nucleus of the conference and others are brought in as needed. A diagnostic case history, with the assets and the problems to be discussed, is prepared and sent out in advance or handed to the members as they come into the conference. The staff member who is carrying the family presents the case.

The description of this plan aroused a great deal of interest and brought many questions from the group.

SUPERVISORS—URBAN AGENCIES

Forty-eight supervisors representing twenty states were present at this Round Table. The subject, "What Are We Doing to Prepare Nurses for Supervisory Responsibility?" was discussed under the leadership of Rosemary Phillips, Nursing Supervisor, Parochial School Health Service, St. Louis, Missouri. A paper describing methods which have been used by the Henry Street Visiting Nurse Service for training nurses for supervision was presented by Mabel E. Grover, Supervisor. It was discussed by Florence Dierberg, Educational Director of the Visiting Nurse Association of St. Louis, Missouri.

Miss Grover outlined specifically two plans for giving staff nurses participation in supervision:

The first, called *senior staff experience,* grew out of a desire on the part of staff nurses for more experience in supervision. A special four-months period of training was arranged, after the

nurse had been carefully selected on the basis of certain personal and professional qualifications and background. During this four-months period, the nurse worked only about half-time in her own district, and the other half was spent assisting the supervisor and educational director with the introduction to the field and supervision of students.

Because of the difficulty of making this plan available to all of the nurses who wanted it, it was discontinued in favor of a second plan called *senior advisory experience,* a modification of the first plan which is designed to give opportunity for growth to a larger number of staff nurses. Under this plan the choice of a staff member does not in any way presuppose that she is interested in supervision as a career, and the requirements for selection are modified somewhat. Each new student and new staff nurse is assigned to a *senior adviser* who, under the direction of the supervisors, plans and guides the new nurse's experience and evaluates her work.

A three-fold plan for training staff nurses for supervision was outlined by Lillian Venable, Regional Supervisor, New York City Health Department.

1. During period as field nurse, thorough:
   a. Participation in staff conferences
   b. Rotation of services
   c. Experience as acting supervisor
   d. Experience in clinic supervision
2. During introduction to supervision following civil service promotion (one-month period) through materials on:
   a. Administrative set-up of board of health
   b. Philosophy of supervision
   c. Specialized areas of service
   d. Educational aspects of supervision
3. Continuous training in service, through:
   a. Conferences of supervisory nurses
   b. Scholarships
   c. Counseling services of the educational staff

Some of the points brought out in open discussion were:

1. That emphasis on participation as a method in learning is highly desirable.
2. That participation in a student program is a definite stimulus to the staff nurse and develops her sense of responsibility.
3. That give-and-take experience between student and staff nurses is sound.
4. That staff nurses who assist in the supervision of students are stimulated through learning from the students about recent developments in medicine and hospital practices.
5. That the plans described above have definite values in developing competent staff nurses as well as supervisors.
6. That staff nurses who have had such special training in supervision and who have not gone into supervisory positions consider that they make better contributions as staff nurses for having had this experience.
7. That plans for supervisory training such as were discussed at this Round Table indicate a definite responsibility on the part of the organization toward the improvement of public health nursing over the entire country—since supervisors leave and take positions elsewhere.
8. That such a training program would need especially careful consideration in a situation where there is a rapid turnover in staff.
9. That where the organization is understaffed a considerable number of nurses could not be taken from the field at one time for such a training period.

SUPERVISORS—RURAL AGENCIES

The problem of rural supervision was approached from two different angles, the educational and administrative, under the leadership of Mary McQuillen, Supervising Nurse, Utah State Board of Health. The administrative functions of the nursing supervisor were outlined by Jean Henry, Assistant Director, Division of Public Health Nursing, New York State Department of Health; the

educational side by Helen I. Stockton, Director of Staff Education, Nursing Divisions, Jefferson County Board of Health, Birmingham, Alabama.

The administrative activities were discussed under the following classifications: interpretation, organization, promotion, evaluation, and education. It was emphasized, however, that education and administration cannot be separated since there is education in administration and administration in teaching.

A great deal of interest in the supervisory records and reports was evidenced. It was pointed out that in New York State, the supervising nurse submits regular reports of the nursing activities in her district to the director of the nursing division. In instances where the supervisor is not a resident of the supervised district, her reports are prepared and discussed with the health officer and staff nurse before she leaves the district.

The various methods of educational supervision discussed were the case conference, the study of records, the field visit, and the staff conference. One outstanding problem of the group-conference method is the reluctance on the part of staff nurses to participate before their own group. It was suggested that supervisors endeavor to find ways to facilitate staff nurse participation.

It was emphasized that the success of the program depends upon mutual understanding and the establishment of supervisor-nurse rapport. This requires that the supervisor have a knowledge of the abilities, personality, and attitudes of the staff nurse.

It was brought out that psychometric and personality tests are being used in some places as tools in the selection of nurses. The information gleaned from these tests is valuable in giving the supervisor a better understanding of the nurse.

Miss Henry's paper was discussed by Adelia Eggestine, Advisory Nurse, Rural Health Unit, District No. 1, Minnesota Department of Health, Bemidji, Minn., and by Helen James, Regional Consultant, New Mexico Department of Public Health. Miss Stockton's paper was discussed by Laura C. Harstad, Maternal and Child Welfare Consultant, Division of Public Health Nursing, Oregon State Board of Health.

The discussions covered two plans for supervision in rural areas: The first is the decentralized plan in which the supervising nurse renders generalized supervision in a circumscribed area. She is resident within her district and plans the frequency of her field visits and the amount of time spent with the nurse in accordance with individual needs.

The second plan is the centralized plan in which the supervising nurse has her residence at state headquarters. She visits the various districts at the request of the district health officers.

STAFF NURSES—URBAN

The subject "The Staff Nurse Analyzes Her Own Work and Plans to Develop Her Skills," was discussed under the leadership of Emily F. Brickley, Visiting Nurse Association, Omaha, Nebraska. A paper on the subject was read by Mrs. Luella Lewis, Visiting Nurse Association, Detroit, Michigan, (see page 420) and discussed by Vera Clark, Instructive District Nursing Association, Des Moines, Iowa, and Urith Thombs, Public Health Nursing Association, Columbus, Ohio. An interesting open discussion followed.

The report of the round table was presented in poster form.

The first part of the subject, "The staff nurse analyzes her own work," is represented in the posters by a figure examining herself closely through a magnifying glass. She looks first at her own personality, including such quali-

fications as loyalty, adjustability, good health, and neat appearance. These are illustrated by a public health nurse with her hand outstretched in friendliness. She looks also at her teaching ability, illustrated by a nurse demonstrating a baby's bath to a mother—particular emphasis being placed on teaching by demonstration. Next she considers her nursing skill, which should be excellent, but which needs "brushing up" from time to time. Last she considers her recording, which should be done completely and neatly in the shortest time possible.

After the staff nurse has analyzed her work, she should plan to develop her skills. This was illustrated by the next three posters. The first, entitled "Keeping Up with the Job," shows a public health nurse seated comfortably and reading. The PUBLIC HEALTH NURSING magazine is featured. Various ways by which she may keep up with her job include professional reading, staff education, meetings, institutes, and conventions.

Not only must the public health nurse keep up with her job, but also with a fast-revolving world. The next poster illustrates ways in which she may do this. It shows figures representing sports, music, arts, and religion.

The last poster depicts "Advanced Education," illustrated by showing a public health nurse arm in arm with a nurse receiving her degree or other recognition for advanced preparation.

STAFF NURSES—RURAL

Relationships in rural health units were discussed in three papers under the leadership of Elizabeth Waterbury, State Supervising Nurse, District Office, New York State Department of Health, Batavia, New York. A rural health unit was defined as any rural county where one nurse is working alone—as well as where there is an organized health department.

Relationships within the health unit and relationships of the health unit to the community were discussed by Joy B. Stuart, State Maternal and Child Health Advisory Nurse, Utah State Board of Health, who stressed the importance of sound working relationships within the staff, and cordial and healthy relationships with coworkers belonging to the other professional and nonprofessional groups in the community. She said that the nurse should be well acquainted with the objectives of these workers and organizations and respect their professional skills and areas of work as well as their personalities. Emphasis was placed upon having frequent conferences with these groups to bring about mutual understanding and thereby to render a better service to the community. No health worker can work alone without the support of the community, and coöperation is vital to effective accomplishment. Miss Stuart emphasized the relationship of the health unit personnel to the man on the street who actually finances the service and for whom the service exists.

The discussion which followed revealed that among those nurses present only a few gave bedside care, while others gave it for demonstration only.

Relationships of the federal and state consultant to the health unit were discussed by Helen Bean, Public Health Nursing Consultant, U. S. Public Health Service, who explained how the consultant can be of service to rural nurses through the public health nursing bureau or division of their state department of health. She stressed the fact that functioning through this channel is essential for sound relationships. The chief objective of the consultant service is to strengthen the state public health nursing consultation service so that nursing leadership may emanate through the state department of health. Miss

Bean said that in 1937 each of the 51 state and territorial health departments had some type of public health nursing organization, whereas in 1931 only 38 departments had a public health nursing unit of any kind. While most states now have a provision for giving adequate supervisory service to the nurse working alone, others do not provide as much as the nurses think they need. This last point was brought out in the open discussion following the papers.

The rural health unit as an educational center was discussed by Eula Butzerin, Associate Professor of Nursing Education, University of Chicago. Miss Butzerin showed by means of a diagram the possible ways in which the rural health unit may serve as an educational center and how relationships are established. She described three types of educational programs:

1. A program developed for and carried on with the regularly appointed professional group of the unit, including regular staff programs for the personnel of the unit, and introductory programs for new staff members.

2. A program for a group or groups outside of the unit but within the state, including (a) a plan of instruction and experience developed coöperatively with the state department of health for the preparation of public health workers, (b) the same for other professional workers, (c) a plan of instruction for volunteer lay health workers and for the general public.

3. A program of advanced education developed in coöperation with an institution of higher education which offers curricula in public health, where the health unit serves as a field agency for field experience of students.

The basic requirements set by the university as necessary for a program of work which can be accredited deal with questions such as adequacy and qualifications of personnel, scope of program, stability and adequacy of finances, soundness of organization, adequacy of physical equipment, soundness of relationships, and preparation to carry on a well planned student program.

The following points were emphasized:

1. The multiple opportunities and obligations for teaching which the health unit faces.

2. The importance of the *teaching* function of the health unit as well as the service function.

3. The need for qualified personnel who are not only equipped to teach but are aware of teaching opportunities.

4. The importance of clearly defined relationships in the development and administration of teaching programs.

5. The importance of the quality of work performed daily by the staff or lone county nurse who gives direct service in the homes and community. It is her work to a great extent which is being observed and studied, and a great deal of the *real success* of the teaching program depends upon the excellence of service which she demonstrates.

BOARD AND COMMITTEE MEMBERS

(Three Round Tables combined)

Due to the fact that the subjects which the board members were discussing—though they were discussed by members representing small and large urban organizations and county organizations—were interesting to all, it was decided to hold one joint meeting of the three Round Tables which were scheduled for board and committee members.

The first report was made by Mrs. S. Emlen Stokes, President of the Moorestown Visiting Nurse Association, Moorestown, New Jersey, a small four-nurse visiting nurse association: Early last fall the education and publicity committee of this organization discussed plans for the board members' study program for the coming winter, which they

presented to the board for approval. It was decided that the first thing the board wanted to know was the relation of the organization to the state health department. Therefore, the assistant epidemiologist of the state health department was invited to meet with the board. This meeting led to a survey by the board of the existing health agencies, both official and nonofficial, in the county. Out of the survey grew the idea of a county health council which it is hoped will be formed in the near future.

An exhaustive study of the Social Security Act was then made, and the ten points that relate to health were reported upon separately. Due to the untiring efforts of one of the board members, disclosures were made which resulted in a complete change of authority in the administration of certain county funds. This all goes to prove that lay interest which is backed up by intelligence, persistence, and tact can do much toward honest public health administration.

Mrs. Arch Trawick, Director of Health Education in Davidson County Department of Health, Nashville, Tennessee, showed how it is possible successfully to use lay participation in county and state boards of health. The whole state is health-minded; parent-teacher associations, the business and professional groups, the Daughters of the American Revolution, and other groups—all have health as their primary interest.

The third part of the meeting centered around board management problems —such as the size and membership of the board; board education; committees; and the content, time of day, number, and length of meetings. This discussion was led by Mrs. Stuart W. Rider, President, Community Health Service, Minneapolis, Minnesota. The time allotted was all too short for questions and for an exchange of ideas, and this Round Table continued wherever two lay members got together at the Convention.

MIDWIFERY SUPERVISION

The purpose of this Round Table was to share experiences and make plans for the supervision of the midwife, who is an important agent in any program for better care for mothers and babies.

The discussion was confined to the problem in the southern states, from Virginia south to Florida and west to Arizona, where in 1936, midwives delivered 174,000 babies and where high maternal and infant death rates are found.

The instruction and supervision of the midwives has been left to the public health nurses.

Reports were made of instruction through clubs for midwives in Mississippi (described by Mary D. Osborne, Supervisor of Public Health Nursing, Division of Maternal and Child Health, State Board of Health) and through small classes and home supervision in Florida (described by Ruth Mettinger, Director, Division of Public Health Nursing, State Board of Health.) Classes for women in the villages on delivery care in case a physician or midwife is not available were reported by Frances Fell, Nurse-Midwife, State Department of Public Health, New Mexico.

Important aspects of midwifery supervision—such as methods and content of instruction, value of supervision in the home, the relative value of teaching and law enforcement, the provision and inspection of equipment, and the results to be sought—were discussed in a paper by Elizabeth R. Ferguson, Nurse-Midwife, Maryland State Department of Health, Charles County, La Plata, Maryland. (To be published in August.)

ORTHOPEDIC NURSING

In the discussion of orthopedic nursing, under the leadership of Elma R. Harrison, Supervisor, Nursing Services, Minnesota State Department of Public Institutions, pertinent points were brought out which are summarized as follows:

1. Orthopedic nursing should be a part of every public health nursing program.

2. Up to the present time most graduate nurses have not had adequate preparation in the field of orthopedic nursing.

3. Orthopedic instruction should begin in the schools of nursing and should be correlated with all other branches of nursing service rather than considered as a separate entity.

4. The preventive aspects of the work in relation to orthopedic defects should be emphasized, and the importance of early and continuous follow-up should be stressed.

5. Public health nurses now in the field should have the opportunity to avail themselves of orthopedic instruction by means of staff education, refresher courses, or university courses in the public health nursing curricula which are already functioning.

Physical-therapy training is desirable for public health nurses in organizations which give a specialized type of service to those who are crippled.

Papers and discussants were as follows: "Field Activities of a Public Health Nurse in an Orthopedic Program," by Mrs. Alice Fitzgerald, Executive Secretary, Association for the Aid of Crippled Children, New York City, was discussed by Phyllis Dacey, Director, Visiting Nurse Association, Kansas City, Missouri, and Carrie Daniels, Supervisor, Community Health Association, Roxbury, Massachusetts. "The Preparation of Nurses for Orthopedic Nursing," by Florence L. Phenix, Assistant Director, Crippled Children Division, Department of Public Instruction, Madison, Wisconsin, was discussed by Ruth Taylor, Public Health Nursing Consultant, Children's Bureau, Washington, D. C.

SCHOOL NURSES

Two hundred and thirty-four nurses attended this Round Table, which was conducted under the leadership of Lula P. Dilworth, Associate in Health and Safety Education, New Jersey State Department of Public Instruction.

A brief report of the study being made under the auspices of the Joint Committee of the National Education Association and the American Medical Association was given by the nurse member of the Committee, Mary Ella Chayer, Assistant Professor of Nursing Education, Teachers College, Columbia University. Although the Committee itself is twenty-five years old, it was not until 1930 that a nurse member was added. In 1936 this present study, made by a subcommittee, began because of the need for the interpretation of school nursing to school administrators. The report, which is called "The School Nurse—Principles and Practices for School Administrators," is still in the making but promises much. It includes sections on basic principles of administration and functions. One principle states, "All work in school should be educational in scope and in function." The study also includes educational principles, objectives, and functions of school nursing, and the application of these to the high schools and to rural schools. The sections now being written are the much needed one on supervision and the one on the certification of school nurses.

Some of the weaknesses of the present

school health program were pointed out by Dr. Henry J. Otto, Consultant in Education, W. K. Kellogg Foundation, Battle Creek, Michigan, who made constructive suggestions for remedying them. ("An Educator Looks at School Health," PUBLIC HEALTH NURSING, June 1938, page 373.)

INDUSTRIAL NURSING SECTION

The Industrial Nursing Section of the N.O.P.H.N. combined its Round Table and business session into one meeting. The Round Table considered two subjects, both presented in the form of papers, with Catherine Dempsey, Industrial Nurse, Simplex Wire and Cable Company, Cambridge, Massachusetts, presiding.

A personnel director—Lloyd R. Sherrill, of Montgomery Ward and Company, Kansas City, Missouri—discussed the importance of skill in human relationships as a fundamental qualification of the nurse in industry. (See June issue, "Getting Along with People," page 385.)

"Selling Nutrition to the Industrial Worker" was discussed by Martha Pittman, Head of Food Economics, Kansas State College. She introduced her discussion with the premise that the health of the industrial worker is fundamental to his efficiency, and said that malnutrition and fatigue caused by unfavorable living and working conditions have been important factors in lowering the health status and productivity of the worker. She suggested various methods of approach to the teaching of nutrition, emphasizing that in every case the teaching must be adapted to the needs, interests, and social and economic status of the worker. She stressed the value of learning the home situation in order to know the worker's needs, and said that "consumer education" of the housewife is of great value in improving the diet of the family. She referred also to the value of a meal service conducted under the supervision of a competent dietitian for the convenience of employees.

The last point in Miss Pittman's speech was developed further by Mabel C. Beeler, Director of the Medical and Welfare Department, Federal Reserve Bank, Kansas City, Missouri, who reported that the number of industrial nurses assuming active supervision of food departments in industry is rapidly increasing. This does not mean that the nurse prepares or serves the food, but she sees that proper food is provided and that it is properly prepared and tastily served so that the best possible health of the employee will be promoted.

Following these papers, the business meeting of the Section was held with Joanna M. Johnson, Supervisor, Industrial Nursing Division, Employers Mutuals, Milwaukee, Wisconsin, presiding.

AMERICAN JOURNAL OF NURSING FOR JULY

Organizing for Better Community Service	C.-E. A. Winslow, Dr.P.H.
Antenuptial Examination Laws	Lee D. Cady, M.D.
Learning About Children	Virginia E. Platt, R.N., and Mrs. Dorothy Henry
Cosmetics	H. H. Hazen, M.D.
Comforts for Cardiac Patients	Anna M. Taylor, R.N.
How to Keep an Ice Bag in Place	Bertha E. Rich, R.N.
Women Ex-Members of the Armed Forces	Charles M. Griffith, M.D.
The Subsidiary Worker	Ella Hasenjaeger, R.N.
What These Alumnæ Did	Kathleen M. Leahy, R.N.
Faculty Committees in Schools of Nursing	Augusta Patton, R.N.

NOTES *from the* NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

A NEW STATISTICIAN FOR THE N.O.P.H.N.

In September, Dorothy E. Wiesner, present Research Secretary for the Family Society of Philadelphia, will come to the N.O.P.H.N. to take Mrs. Anna J. Miller's place as our statistician. Mabel Reid, who has been in the N.O.P.H.N. statistical department for the last two and one-half years, will be assistant to Miss Wiesner.

Miss Wiesner comes to us with a thorough background of experience in statistical work in both health and social fields. She has worked with the Metropolitan Life Insurance Company, the National Tuberculosis Association, and the Philadelphia Health Council and Tuberculosis Committee. She has published articles in the *American Review of Tuberculosis,* shared in the Hospital and Health Survey in Philadelphia, and is a member of the American Association of Social Workers, American Statistical Association, the National Conference of Social Work, and the Philadelphia Council of Special Libraries Association.

Bachrach

DOROTHY E. WIESNER

With these reinforcements in our statistical department, we look forward to greater usefulness in the field of community surveys, studies, and statistical analyses of public health nursing.

REVISION OF N.O.P.H.N. BY-LAWS

A Biennial Convention would not be a Biennial Convention for the N.O.P.H.N. without a change in by-laws! Whether this is a sign of growth or of divine discontent with "things as they are," we do not know. But every two years we find something that we think could be better, and so we recommend it. It is to the credit of the committee which handles these revisions that they are presented to the Board of Directors—and on its recommendation to the membership—in correct legal form. For the desired changes, which nearly always arise out of a conscious need for change on the part of a group, a committee, or the staff, are first presented to the committee in the form of ideas rather than as articles and sections.

All the proposed revisions* were accepted by the membership this year. We

*Sent to every member four weeks in advance of the Biennial Convention and accepted at the regular business meeting of the N.O.P.H.N., April 26, 1938.

will function for the 1938-1940 biennial period under a board of 31 members, with an executive committee of 13. Agency members will, in the future, be entitled to two votes cast by their representatives, who will not lose thereby their right to vote as individual members. And members have a right to vote for any candidates other than those appearing on the ballot, by writing in names of such candidates. The change in the Nominating Committee is, we think, significant. It places the election of the entire committee of five in the hands of the membership, as opposed to the appointment of two committee members by the Board. The Committee also will choose its own chairman instead of this being a Board appointment. Since the Committee for 1938-1940 is already chosen, the change will apply to 1940-1942, and the present Nominating Committee will offer ten names to the membership for election in 1940.

The other important change in our by-laws relates to branches of the N.O.P.H.N. and has seemed to warrant a special announcement at this time. (See below.)

DOROTHY DEMING

BRANCHES OF THE N.O.P.H.N.

One of the most pressing problems presented to the Committee to Study the Functions of the N.O.P.H.N. two years ago concerned our branches, and the members of the Committee spent considerable time and study on all that is implied for the N.O.P.H.N. in recognizing state or regional branches of an organization such as ours. The policy previous to 1937 was to maintain a strictly impartial attitude toward a state which was debating the relative value of a section on public health nursing in the state nurses' association or a branch—that is, an S.O.P.H.N. It was customary to discourage either form of organization in a state with only a small number of public health nurses, and to say to others, "Organize in whatever way seems most helpful to your own situation."

Then as now, the formation of a section on public health nursing in the state nurses' association automatically placed the section outside of N.O.P.H.N. affiliation, since the connection was directly through the state nurses' association to the American Nurses' Association. No section of a state nurses' association can have lay members, a privilege which, along with full voting power, the N.O.P.H.N. stresses with relation to all its own sections, committees, and Board. And necessarily the section in a state is prevented from taking independent action, since it is responsible to the board of the state nurses' association. Nor can the lay groups interested in public health nursing—which have organized as separate state associations in states where there are sections — become branches of the N.O.P.H.N., since public health nurses are not voting members.

All of these points the Functions Committee reviewed, and at the same time it studied the activities and relationships of the existing S.O.P.H.N.'s and the provisions governing them in N.O.P.H.N. by-laws.

The advantages of state organizations which might have a direct connection with the N.O.P.H.N., even though they were not branches in the true sense of taking their life, their charter, and their support from the N.O.P.H.N., seemed to the Functions Committee greater than the advantages of sections. And it was believed that S.O.P.H.N.'s offered a form of organization through which the N.O.P.H.N. might promote the public health nursing movement as a whole as well as public health nursing state by state. There was a strong feeling in the Functions Committee that these state organizations should be closer to the N.O.P.H.N. than in the past, and

that there would be mutual helpfulness in meeting in some sort of a council of state representatives to give advice and help to the National as well as for interchange of information. The Committee therefore recommended and the Board accepted the plan that the Board of Directors offer an affiliating membership in each state to one state organization* which:

1. Has as its primary objective promotion of and interest in all phases of public health nursing.
2. Offers equal voting privileges to nurse and lay members.
3. Renders an annual report of program, activities, officers, et cetera to the N.O.P.H.N.
4. Elects a delegate to represent the affiliating organization on the N.O.P.H.N. council of affiliating members or branches, such delegates to be ex-officio members of the N.O.P.H.N. Board of Directors.

This plan does not in any way change the relationship of existing S.O.P.H.N.'s to the N.O.P.H.N., except to provide for the election of a delegate to the Council of Branches.

The Board also stated formally that the Council of Branches should be composed of duly elected representatives from each affiliating member (one delegate from each); that the Council should meet once a year, preferably at the time the N.O.P.H.N. Board is meeting; that the President of the N.O.P.H.N. should serve as chairman of this Council for organization purposes, after which the chairman will be elected by the Council; and that the members of the Council should be invited to attend meetings of the N.O.P.H.N. Board. A member of the N.O.P.H.N. staff will act as secretary of the Council.

Through this arrangement the Board hopes also that branch membership will strengthen the geographical representation at Board meetings.

The Functions Committee and the Board also went on record as definitely authorizing the N.O.P.H.N. staff to promote this plan of branch membership wherever states or regions seem ready for it. The N.O.P.H.N. by-laws* accepted by the membership in Kansas City, Mo., April 26, 1938, now provide for this step in the following article:

The Board of Directors shall authorize the formation in each state of one branch organization which:

1. Has as its purposes the objects for which the N.O.P.H.N. was formed.
2. Offers membership to both nurses and laymen and offers to both the privilege of voting.
3. Renders an annual report of its program, activities, and officers to the N.O.P.H.N.
4. Elects a delegate to represent it on the Council of Branches of the N.O.P.H.N.

Members of the Council shall be invited to attend regular meetings of the Board of Directors without vote.

We hope that all states not already affiliated with us and interested in forming branches under these conditions will communicate with the N.O.P.H.N.; also, that our present branches will start now to consider the possibility of sending their duly elected delegates to the first organization meeting of the Council of Branches to be held at the time of the 1939 January Board of Directors meetings (generally the third week in January) in New York City. The N.O.P.H.N. will gladly answer questions regarding this new development.

WITH THE STAFF

Since we did not carry any N.O.P.H.N. Notes in the June issue of the magazine, we are including the field activities of staff members for May as well as June. With summer holidays coming along, our activities in the field in June diminished considerably.

Dorothy Deming made a trip to the West Coast to attend the annual meeting of the National Conference of Social Work in Seattle, Wash., the week of June 26. On her way to the Confer-

*This does not prohibit a plan for an organization covering more than one state where this seems advisable.

*See page 437 for summary of new by-laws.

ence, she stopped off in Detroit, Mich., and Portland, Oreg.

Ruth Houlton attended the meeting of the Nurses' Advisory Committee of the National Safety Council in Chicago on May 6 to assist in drafting the program for the industrial nursing sessions of the Silver Jubilee Safety Congress in Chicago next October. On May 19 and 20 she went to Dedham, Mass., to make a survey of the nursing service of the Dedham Emergency Nursing Association. She also assisted in a survey being made of the health and welfare services in Yonkers, N. Y., on June 9, 10, and 11.

Immediately after the Biennial Convention, Evelyn Davis conducted a board members' institute under the auspices of the Volunteer Bureau of the Council of Social Agencies, Kansas City, Mo., on May 2. Upon her return to headquarters, she went to Cedarhurst, N. Y., to give a talk under the auspices of the Council of Social Agencies to a group of board members of various agencies in that community on the subject of board members' responsibility.

Ella McNeil did not return immediately to headquarters from the Biennial Convention but continued further west stopping first in Madison, Wisc., to make a survey of the nursing service of the Attic Angels from April 30 to May 6. From there, she went to Minneapolis, Minn., spending from May 9-11 assisting Dr. Carl Buck of the American Public Health Association in making a survey of the public health nursing services of that city. The survey of public health nursing and welfare services of Minneapolis is being conducted under the auspices of the Community Chests and Councils.

Virginia Jones remained in the field going out to the Pacific Coast to visit public health nursing courses at the University of California, Berkeley, May 2 to 7; University of Oregon, Portland, May 9 to 14; University of Washington, Seattle, May 16 to 21; and the University of California in Los Angeles, May 23 to 28.

Mabel Reid, our assistant statistician, spent two days in the field. She went to Montclair, N. J., on May 26, to observe the work and the record system of the Bureau of Public Health Nursing. On June 1, she went to the Visiting Nurse Association, Newark, N. J., for the same purpose.

HONOR ROLL

Forging ahead to a banner Honor Roll year! We now have 36 more agencies with 100 percent enrollment in the N.O.P.H.N. than we had at this time last year. Let's widen the gap between last year and this and make 1938 a "100 percent year." Be sure to let us know just as soon as your service is completely enrolled in the N.O.P.H.N. and you will receive a Certificate of Honor as well as being listed in a coming issue of the magazine.

Asterisks denote the number of years an agency has been on the Honor Roll, up to five years; the dagger indicates those agencies which have been Honor Roll members for five years or more.

ALABAMA

***Metropolitan Life Insurance Nursing Service, Anniston
**Metropolitan Life Insurance Nursing Service, Birmingham
**Pickens County Health Department, Carrollton
*Greene County Health Department, Eutaw
**DeKalb County Health Department, Fort Payne
**Marshall County Health Department, Guntersville
**Marengo County Health Unit, Linden
****Bureau of Hygiene and Nursing, State Health Department, Montgomery
****Pike County Health Unit, Troy

ARIZONA

***Mohave County Schools, Kingman
**Miami Public Schools, Miami
***Pima County Health Unit, Tucson

ARKANSAS

***Little Ricer County Health Unit, Ashdown
****Independence County Health Department, Batesville

***Fort Smith Public Schools, Fort Smith
**Ashley County Health Unit, Hamburg
*Visiting Nurse Association of Greater Little Rock, Little Rock
**Columbia County Nursing Service, Magnolia

CALIFORNIA

****Coalinga Union High School District, Coalinga
**Imperial County Health Department, El Centro
†Pittsburg Public Schools, Pittsburg
**Junior Aid Visiting Nurse, Riverside
**Metropolitan Life Insurance Nursing Service, San Jose
†Santa Barbara Visiting Nurse Association, Santa Barbara

COLORADO

**Montezuma County Nursing Service, Cortez
**Delta County Nursing Service, Delta
†Visiting Nurse Association, Denver
**Durango Public Schools, Durango
†Weld County Public Health Nursing Service, Greeley
**Lincoln County Nursing Service, Hugo
**Indian Reservation School of Ignacio, Ignacio
**Bent County Health Unit, Las Animas

CONNECTICUT

**Cheshire Public Health Nursing Association, Cheshire
****District Nurse Association of Ansonia, Derby and Shelton, Derby
***Public Health Nurse Association, Guilford
***Salisbury Public Health Nursing Association, Lakeville
**Public Health and Visiting Nurse Association, Meriden
†Naugatuck Chapter, American Red Cross, Naugatuck
†Newtown Visiting Nurse Association, Newtown
***Red Cross Nursing Service, Putnam
***Metropolitan Life Insurance Nursing Service, South Norwalk

DELAWARE

**Metropolitan Life Insurance Nursing Service, Dover

DISTRICT OF COLUMBIA

†American Red Cross, National Headquarters, Washington
***United States Public Health Service, Washington

FLORIDA

**Broward County Health Department, Fort Lauderdale
*St. Lucie County School Nurse, Fort Pierce
****Osceola County Public Health Nursing Service, Kissimmee
****Escambia County Health Department, Pensacola
**Sarasota County Division of State Board of Health, Sarasota

GEORGIA

*Atlanta Branch, General Shoe Corporation, Atlanta
†Metropolitan Life Insurance Nursing Service, Atlanta
*Clinch County Department of Health, Homerville
*Walton County Health Department, Monroe
*Worth County Board of Health, Sylvester

IDAHO

***Bunker Hill and Sullivan Mining and Concentrating Company, Kellogg
***Nez Perce County Health Department, Lewiston
**South Central District Health Unit, Twin Falls

ILLINOIS

†Metropolitan Life Insurance Nursing Service, Alton
***Belleville Public Schools, Belleville
***Metropolitan Life Insurance Nursing Service, Belleville
**Goodman Manufacturing Company, Chicago
***Metropolitan Life Insurance Nursing Service, Chicago
****Evanston Infant Welfare Society, Evanston
†Evanston Visiting Nurse Association, Evanston
†Amity Society, Freeport
***Stephenson County Tuberculosis Board, Freeport
**Metropolitan Life Insurance Nursing Service, Granite City
**Morgan County Health Department, Jacksonville
***Metropolitan Life Insurance Nursing Service, Oak Park
***Public Health Nursing Association, Peoria
**Livingston County Public Health Nursing Association, Pontiac
***Cheerful Home Association, Quincy
†Sangamon County Tuberculosis Sanitarium Board, Springfield
†Winnetka Relief and Aid Society, Winnetka

INDIANA

*Ohio County Health Department, Rising Sun
†City Schools, Terre Haute

IOWA

†Public Health Nursing Association, Muscatine
†Visiting Nurse Association, Sioux City
***Woodbury County Health Unit, Sioux City
*Health Department East Waterloo Public Schools, Waterloo

KANSAS

*Gray County Health Department, Cimarron
†Visiting Nurse Association, Kansas City
*Wyandotte County Red Cross Chapter,

Kansas City
**Rice County Maternal and Infant Nursing Service, Lyons
****McPherson County Public Health Nursing Service, McPherson
**Newton Public Health Association, Newton
*Haskell County Health Department, Sublette
***Coleman Lamp Company, Wichita

KENTUCKY
**Metropolitan Life Insurance Nursing Service, Henderson

LOUISIANA
*Rapides Parish Health Unit, Alexandria
†Industrial and Visiting Nurse Staff, Standard Oil Company, Baton Rouge
**De Soto Parish Health Unit, Mansfield
***Child Welfare and Community Health Association, New Orleans

MAINE
†Gardiner Public Health Association, Gardiner
***Mt. Desert Chapter, American Red Cross, Northeast Harbor
***Central Penobscot Public Health Association, Old Town

MARYLAND
***Metropolitan Life Insurance Nursing Service, Annapolis
**Dorchester County Tuberculosis Association, Inc., Cambridge

MASSACHUSETTS
**Board of Health, Arlington
**State Department of Public Health, Boston
****Cambridge Visiting Nursing Association, Cambridge
****Dedham Emergency Nursing Association, Dedham
†Milford, Hopedale, Mendon Instructive District Nursing Association, Milford
****Instructive Nursing Association, New Bedford
**Pembroke Public Health Nursing Association, Pembroke
†Worcester Society for District Nursing, Worcester

MICHIGAN
***Ann Arbor Public Health Nursing Association, Ann Arbor
****Board of Education, Berkley
***Bureau of Public Health Nursing, City of Grand Rapids Health Department, Grand Rapids
†Community Health Service of Grand Rapids, Grand Rapids
****Kent County Health Department, Grand Rapids
*Mason-Manistee County Health Unit No. 8, Manistee
*Muskegon County Health Department, Muskegon

MINNESOTA
**Arrowhead Unit, District No. 4, Duluth
**State Teachers College, Duluth
*McLeod County Public Health Association, Glencoe
*Board of Education, Hutchinson
***Sand Beach Sanatorium, Lake Park
****Community Health Service, Minneapolis
***Division of Child Hygiene, State Department of Health, Minneapolis
**Hennepin County Nursing Service, Minneapolis

MISSISSIPPI
**Metropolitan Life Insurance Nursing Service, Biloxi
*Copiah County Health Department, Hazelhurst
**Metropolitan Life Insurance Nursing Service, Laurel

MISSOURI
**Metropolitan Life Insurance Nursing Service, Cape Girardeau
***Metropolitan Life Insurance Nursing Service, Moberly
*Ray County Public Health Nursing Service, Richmond
***Atchison County Health Service, Rock Port

MONTANA
***State Normal College and Public School System, Dillon

NEBRASKA
**Columbus Public Schools, Columbus

NEW HAMPSHIRE
†Ossipee Chapter, American Red Cross, Center Ossipee
**Bradford School Nursing District, Concord
†Milton Branch, American Red Cross, Milton
****Pittsfield Public Health Nursing Association, Pittsfield

NEW JERSEY
****Bridgeton Chapter, American Red Cross, Bridgeton
†Camden County Tuberculosis Association, Camden
***Cape May Chapter, American Red Cross, Cape May
***Elizabeth Visiting Nurse Association, Elizabeth
***Keyport Red Cross Public Health Nursing Association, Keyport
†Matawan Public Health Association, Matawan
†Merchantville-Pennsauken Visiting Nurse Association, Merchantville
**Millville Public Schools, Millville
†Montclair Bureau of Public Health Nursing, Montclair
†Visiting Nurse Association, Orange
†Monmouth County Organization for Social Service, Inc., Red Bank
***Lowe Paper Company, Ridgefield
**Salem City Board of Education, Salem
†District Nursing Association, Westfield

NEW MEXICO
***Bureau of Public Health, Clovis
**Colfax County Health Department, Raton

†Socorro County Nursing Service, Socorro
**United States Indian Service, Tohatchi
†Quay County Health Department, Tucumcari

NEW YORK

*Akron Public Schools, Akron
**New York State Education Department, Albany
†Cayuga County Committee on Tuberculosis and Public Health, Auburn
***Metropolitan Life Insurance Nursing Service, Batavia
**Metropolitan Life Insurance Nursing Service, Beacon
*Metropolitan Life Insurance Nursing Service, Cortland
***Metropolitan Life Insurance Nursing Service, Far Rockaway
****Public School No. 7, Hartsdale
***Township of Marlboro Nursing Service, Milton
***Crowell Publishing Company, New York
*Riverside Branch, Henry Street Visiting Nurse Service, New York
†Metropolitan Life Insurance Home Office Administrative Nursing Staff, New York
***Public Health Association of Putnam Valley and Kent District No. 1
***Metropolitan Life Insurance Nursing Service, Port Jervis
†Dutchess County Health Association, Poughkeepsie
**Onteora Branch, Greene County Chapter, American Red Cross, Tannersville
**Metropolitan Life Insurance Nursing Service, Watertown

NORTH CAROLINA

***Metropolitan Life Insurance Nursing Service, Burlington
***Metropolitan Life Insurance Nursing Service, Charlotte
**Metropolitan Life Insurance Nursing Service, High Point

NORTH DAKOTA

****Cass County Health Department, Fargo
*Steele County Public Health Nursing Service, Finley
*City of Mandan Public Health Nurse, Mandan
**City and School Public Health Nurse, Valley City

OHIO

****Metropolitan Life Insurance Nursing Service, Akron
**Metropolitan Life Insurance Nursing Service, Ashtabula
****Barberton Red Cross Nursing Service, Barberton
*Williams County Board of Health, Bryan
***Metropolitan Life Insurance Nursing Service, East Liverpool
*Metropolitan Life Insurance Nursing Service, Elyria
****Kent Red Cross Visiting Nurse Association, Kent
***Metropolitan Life Insurance Nursing Service, New Philadelphia
**Metropolitan Life Insurance Nursing Service, Sandusky
***Public Health League, Shelby
**Metropolitan Life Insurance Nursing Service, Springfield
**Metropolitan Life Insurance Nursing Service, Zanesville

OKLAHOMA

†Oklahoma City Public Health Nursing Bureau, Oklahoma City
***Metropolitan Life Insurance Nursing Service, Tulsa

OREGON

*Clatsop County Health Unit, Astoria
**Deschutes County Health Association, Bend
*Coos County Health Unit, Coquille
**Hood River County Health Association, Hood River
**Malheur County Public Health Association, Ontario
***Umatilla County Public Health Association, Pendleton
†Oregon Tuberculosis Association, Portland
**State Board of Health, Division of Public Health Nursing, Portland
***Marion County Department of Health, Salem
***Wasco County Public Health Association, The Dalles

PENNSYLVANIA

**Metropolitan Life Insurance Nursing Service, Altoona
†North Penn Community Center, Ambler
†Delaware County Tuberculosis Association, Chester
†Visiting Nurse Association of Fleetwood and Vicinity, Fleetwood
****Wayne County Chapter, American Red Cross, Honesdale
†Latrobe Chapter, American Red Cross, Latrobe
***Visiting Nurse Association, Lebanon
†Red Cross Community Nursing Service, Morrisville
****Mount Pleasant Red Cross, Mount Pleasant
**Metropolitan Life Insurance Nursing Service, Pottsville
†Service Circle of the King's Daughters, Pottsville
****Visiting Nurse Association of Scranton and Lackawanna County, Scranton
**Ella Peach School, Uniontown
****Chester Valley Red Cross Community Nurse Association, Whitford

RHODE ISLAND

****Barrington Visiting Nurse Association, Barrington
†Bristol District Nursing Association, Bristol
†Richmond Visiting Nurse Association, Carolina
**North Providence District and Tuberculosis Association, North Providence

†Portsmouth Branch, American Red Cross, Portsmouth
***Builders Iron Foundry, Providence
**New England Telephone and Telegraph Company, Providence
**The Texas Company, Providence
****Universal Winding Company, Providence
†Sayles Finishing Plants, Inc., Saylesville
†Warren District Nursing Association, Warren

SOUTH CAROLINA

*Metropolitan Life Insurance Nursing Service, Charleston
***Metropolitan Life Insurance Nursing Service, Greenville

SOUTH DAKOTA

**Brown County Health Department, Aberdeen
**Public Schools, Brookings
**Board of Education School Nurse, Yankton

TENNESSEE

***Metropolitan Life Insurance Nursing Service, Bristol
****Metropolitan Life Insurance Nursing Service, Knoxville
†Department of Nursing Education, George Peabody College, Nashville
†Metropolitan Life Insurance Nursing Service, Nashville
***Hardin County Health Department, Savannah

TEXAS

*Taylor County Tuberculosis Association, Abilene
*Potter County Tuberculosis Association, Amarillo
*Chambers County Health Department, Anahuac
*Brazoria County Public Health Nursing Service, Angleton
*Henderson County Nursing Service, Athens
*Texas Tuberculosis Association, Austin
*Travis County Health Department, Austin
*Runnels County Health Department, Ballinger
**Matagorda County Health Department, Bay City
****Brazos County Public Health Board, Bryan
*State Health Department, Public Health District No. 4, Bryan
*Milam County Public Health Board, Cameron
*Van Zandt County Health Department, Canton
*Nueces County Health Unit, Corpus Christi
*Zavala County Health Department, Crystal City
†Dallas Public School Nursing Service, Dallas
*Denison School Nursing Service, Denison
*Freestone County Health Department, Fairfield
*State Department of Health, District No. 1, Floydada
*Cooke County Health Department, Gainesville
*Galveston Anti-Tuberculosis Association, Galveston
†Galveston Public Health Nursing Service, Galveston
*Rusk County Health Department, Henderson
*Hill County Health Department, Hillsboro
*Southern Pacific Railroad, Houston
*State Department of Health, District No. 3, Kaufman
***Kerr County Public Health Nursing Service, Kerrville
*State Department of Health, District No. 5, Kingsville
*San Angelo School Nursing Service, Knickerbocker
*Hardin County Health Department, Kountze
*Lefors School Nursing Service, Lefors
*Hockley County Health Department, Levelland
*Liberty County Health Department, Liberty
*Polk County Health Department, Livingston
*Midland County Health Department, Midland
*Mineral Wells School Nursing Service, Mineral Wells
*State Department of Health, District No. 2, Mineral Wells
*Independent Humble Oil Company, Monroe City
*Carson County Health Department, Panhandle
*State Department of Health, District No. 6, San Angelo
***Tom Green County Health Association, San Angelo
*Sherman School Nursing Service, Sherman
*Nolan County Health Unit, Sweetwater
*Smith County Health Unit, Tyler
*Tyler School Nursing Service, Tyler
*Uvalde County Public Health Nurse Service, Uvalde

UTAH

**Uintah Basin Nurses, Vernal

VERMONT

*Barre Chapter, American Red Cross, Barre

VIRGINIA

***Metropolitan Life Insurance Nursing Service, Alexandria
***Metropolitan Life Insurance Nursing Service, Danville
***Fairfax County Health Department, Fairfax
****Prince Edward County Health Department, Farmville
**Metropolitan Life Insurance Nursing Service, Lynchburg

(Continued on advertising page 5)

EDITED BY
ELLA E. McNEIL

A SOCIAL STUDY OF PITTSBURGH

By Philip Klein and collaborators. 958pp. Columbia University Press, New York, 1938. $4.75.

Packed into the thousand pages in this volume is a thorough uncensored analysis of the social and economic conditions in Pittsburgh and Allegheny County, Pennsylvania, and of the work of social and health agencies in coping with problems caused by these conditions. This social study (not survey!) is exciting to read. Its broad recommendations for future development are a challenge to every social worker and every volunteer community leader.

The field of public health receives a careful study by experts and the general recommendations can be applied not only to Pittsburgh but to any community. The study suggests consolidation of all public health nursing under the department of health and states that it is a matter of sound policy that tax funds should be expended by public authorities and not through private agencies.

But it admits that in the health field the community will require for a considerable time the supplementing of public services by private associations.

While the study recognizes great advances in the past thirty years in public health, it points out that there is still much to be done. The importance of the work of the public health nurse is emphasized by the statement that she is involved—or should be involved—in every phase of a community health program.

We may disagree with some of the underlying philosophy in this study. But we must admire the frankness of this study, the foresight of the committee of citizens who asked for it, and the courage of the experts and directors who did the research and wrote their findings and conclusions. The whole book is a challenge to our ability to adapt ourselves to a rapidly changing philosophy in the American community. It should be on the "must" list for study by every city in these United States.

HARRY M. CAREY
Providence, Rhode Island

SEX LIFE IN MARRIAGE

By Oliver M. Butterfield. 192pp. Emerson Books, Inc., New York, 1937. $2.

This book is the outgrowth of the author's booklet, "Marriage and Sexual Harmony." The text is written in clear and simple language. Engaged or married couples will find sensible answers to most questions they may wish to ask concerning sexual relations in married life. The chapter on Overcoming Sexual Maladjustments is particularly good. No book on marital problems will be entirely satisfactory until it is possible to have a full and frank discussion of contraceptive methods. The brief discussion of sterility might be enlarged with profit. The idea of planned families presupposes a knowledge of how to have children as well as how not to have them.

There is still a place for the brief presentation of the subject so well done by the author in "Marriage and Sexual Harmony," which was particularly desirable for many engaged persons.

H. M. N. WYNNE, M.D.
Minneapolis, Minnesota

THE SOCIAL COMPONENT IN MEDICAL CARE

By Janet Thornton and Marjorie Strauss Knauth. 411pp. The Columbia University Press, New York, 1937. $3.

This study of one hundred patients at Presbyterian Hospital, New York City, is a coöperative effort of the medical and social service departments of that institution to determine what effect social strain has on the patient's loss of health and recovery from illness. This is in line with the present tendency to consider the diseased individual as of primary importance rather than the disease itself. All social factors which would tend to produce malnutrition, overfatigue, or excessive emotional tension in these patients were considered appropriate to the study. *Social* as used in this study includes not only such obvious hardships as too heavy labor or multiple responsibilities, but the association with other people in these situations, and the patient's individual reaction to the strain of such association.

One of the contributions of this study is its emphasis on the variety of causes which produce the general symptoms of fatigue and emotional tension. This means that the help offered must be appropriate to the cause rather than symptomatic treatment. A helpful distinction is made between "restless idleness" and "restorative rest."

The social service department of the hospital is found in this study to be a "service adjunct to the practitioner," which under the kind of medical leadership given here can help to discover and control certain adverse social factors. The public health nurse is also a service adjunct to the physician. While her service usually does not include direct therapy in the social service sense, she needs knowledge of social factors contributing to illness, and needs the help of such studies as this in evaluating social factors in the many family situations of which she is a part.

RUTH GILBERT, R.N.
Hartford, Connecticut

MAN AGAINST HIMSELF

By Karl A. Menninger. 485pp. Harcourt, Brace and Company, New York, 1938. $3.75.

A perspective of *Man Against Himself* shows three facets: A literary effort in the form of a contribution to the anatomy of suicide, a treatise on the psychopathology of suicide, and finally, a manual of the therapy of potential suicide.

As a literary effort this is a finely wrought piece of work. Menninger has collected his material from many sources and put them together cleverly, and they will stand as useful references. As a study of the psychopathology of suicide, the book is marred by a rigid and single-minded devotion to Freud's theory of the death wish.

The chapter on Alcohol Addiction is not up to the standard of the other chapters. The potential alcoholic is not the jolly, carefree extrovert, but the introvert, who superficially seeks extroversion but actually deeply woos phantasy in the contents of the bottle.

The two chapters on Reconstruction are good. Menninger feels that therapeutic advances will come from measures which will diminish the aggressive element, lessen the self-punitive element, and enhance the erotic element. In these chapters and in the therapeutic suggestions in the chapter on the Psychological Factor in Organic Disease, Menninger shows himself more the clinical psychiatrist and less the psychoanalyst and wisely discards some of the tenets of formal analytic therapy. He suggests that the therapist do some of the talking and he makes provocative suggestions concerning the utilization of environmental sublimations.

Man Against Himself is a book for psychopathologists, psychiatric and lay. Conceivably in some instances it might increase the difficulties of the neurotic patient who reads it. A small group of neurotic patients might be helped.

EDWARD A. STRECKER, M.D.
Philadelphia, Pennsylvania

THE FAMILY AS A UNIT FOR NURSING SERVICE

By Helen Bean and Georgie S. Brockett. Public Health Reports, U. S. Public Health Service, Washington, D. C., December 31, 1937. 5c.

This is one of a series of analyses of nursing records obtained in a study of county health department practice made by the U. S. Public Health Service. The objective of this particular analysis was to determine the extent to which the principle of rendering "family health service" was actually applied in the visits studied. The data are based on records of three counties for the period of one year, and are limited to cases for whom family folders were opened. As the authors point out, only services which are recorded can be considered in such an analysis, and the results are, therefore, qualified by the degree of completeness of recording.

The conclusion is reached that, "Little or no evidence can be found that the nurses were rendering a complete family service . . . Their visits seemed to be confined to services for one or two members of the family, with very little attention given to the development of constructive programs for the family as a social unit." A. J. M.

TWO BOOKS ON SOCIOLOGY

Introductory Sociology. By Robert L. Sutherland and Julian L. Woodward. 720pp. J. B. Lippincott Company, Philadelphia, 1937. $3.50.

The Social World and Its Institutions. By James A. Quinn. 992pp. J. B. Lippincott Company, Philadelphia, 1937. $2.20.

Rarely does one find a textbook in sociology which tempts one to read it word for word merely for the interest it invokes. The book *Introductory Sociology* seems to be that kind. It includes an analysis of all the concepts in the field of sociology recommended for the introductory course by the special committee of the American Sociological Society in 1932. Generally favorable reviews of it have appeared in sociological journals. It is especially adaptable for teaching, since its material is divided into several parts which can be arranged in any order to suit the needs of a group. The titles of the six parts—Man's Cultural Heritage, Man's Social Nature, Forms of Collective Behavior, Community and Social Organization, Social Interaction, and Social Change—should appeal to public health nurses as suggesting material of particular interest to them.

Another book called *The Social World and Its Institutions* written for high-school students by James A. Quinn, Department of Sociology, University of Cincinnati covers somewhat the same material but in a slightly more elementary manner. It provides very practical and provocative questions for student discussion. V. J.

BOARD MEMBER SOUL-SEARCHING

By Ruth Hyde Harvie, President, Association of the Junior Leagues of America. *Survey Midmonthly*, 112 East 19 Street, New York, March 1938.

An article taken from a paper presented at the New York State Conference on Social Work shows the way organizations through self-study can correlate their work more efficiently. Familiar problems are brought to light when a lay and professional group review together their policies, practices, administration, management, history, and purpose—collecting all data, discussing, revamping, discarding, and setting it all up in manual form. This article clearly defines the duties of the board, the executive committee, the executive director, and the staff. Through this process of study, the layman finds his value as an interpreter and co-planner with the professional in developing community service. Mrs. Harvie presents this subject in a constructive and challenging manner. There are many worthwhile ideas which can be utilized by any organization interested in improving its standards and making more efficient its service.

MRS. MARGARET D. BRIGHT
Worcester, Massachusetts

• "Public Health in the World of Tomorrow" will be the theme of the next annual meeting of the American Public Health Association to be held in Kansas City, Mo., October 25-28. An attendance of 3000 is expected, coming from every state in the Union, from Canada, Cuba, and Mexico, and from abroad.

• New York State nurses registered and actively practicing in the state, under the new Todd law, need only register every second year instead of annually. The law becomes effective July 1, 1938. The 1937-1938 registration cards to practice in the state are valid until August 31, 1939. Nurses will not receive application cards for reregistration until May 1939.

• An announcement of the appointment of Philip S. Broughton to take charge of the Office of Public Health Education was made in *The Health Officer* for January 1938. The appointment was made by Surgeon General Thomas Parran. The primary objectives of the office will be, according to the announcement, "to demonstrate by precept and example the modern techniques of health information. Emphasis will be primarily on the presentation of publications for the layman, attractive not only in content but in format as well."

• Results of the sixth annual national traffic safety contest were announced on March 31 by the National Safety Council. The national grand prizes were awarded to Memphis, Tenn., for the contest between cities, and to Massachusetts for the contest between states. Six cities won first-place prizes in their respective population groups: Milwaukee, Wis., Hartford, Conn., Beaumont, Tex., Sacramento, Calif., Everett, Wash., and Des Plaines, Ill. Other winning states were Oklahoma, North Dakota, and Nevada.

• The annual conference of the New York State Charities Aid Association's state and local tuberculosis and health committees was held on May 24, 25, and 26 at the Hotel Commodore, New York, N. Y. The conference was open to individuals and organizations interested in and concerned with tuberculosis and syphilis control, health instruction of school children, coöperation between official and non-official health agencies, and fund-raising through the Christmas Seal Sale.

• A school health education institute was held in Ann Arbor, Mich., on May 27 and 28. This institute was sponsored by the Division of Hygiene and Public Health and the Extension Service of the University of Michigan in coöperation with the Michigan School Health Association.

• The Cured Cancer Club of the American Society for the Control of Cancer was launched in New York City at the opening of the Society's Twenty-fifth Anniversary Exhibit, "Cancer Can Be Cured," on March 25. The purpose of the Club is to end once and for all the popular feeling that cancer is an incurable disease. Many local units are expected to be launched next fall. Membership in the club is open to all those sponsored by recognized physicians as having been cured of cancer for five or more years.

• The number of cases of measles reported to the U. S. Public Health Service shows that 1938 is the highest measles year in ten years, according to *The Health Officer* for March 1938. Factors contributing to the unusually high incidence shown in the reports are the better reporting of the disease and the fact that "some of the most populous sections are having their 'measles year' simultaneously."

• The Leslie Dana Gold Medal will be presented this year to Dr. Ellice M. Alger, Professor of Ophthalmology at the New York Post-Graduate Medical School and one of the founders of The National Society for the Prevention of Blindness. This medal is awarded annually for "outstanding achievements in the prevention of blindness and the conservation of vision."

• In order to amend the Social Security Act so as to authorize additional appropriations for extending and improving maternity care and the care of infants, companion bills have been introduced in Congress by Senator Alben W. Barkley and Representative Robert L. Doughton. If the Act is amended, the funds appropriated for this purpose will be administered by the U. S. Children's Bureau, which now administers the $3,800,000 for federal grants to the states for maternal and child health services as authorized in Section 501 of the Social Security Act.

• A cookbook for blind women has been prepared by the volunteers of the Brooklyn, N. Y., Chapter of the American Red Cross. This book comprises 233 pages in three braille volumes.

• In the recommendations of the Committee on Care of Transient and Homeless presented to the Senate Committee on Unemployment and Relief on March 14 the health problems involved in transiency were stressed. The problem of transients as carriers of disease and the need for medical care of the transient indigent sick—who are ineligible for local community care—were brought out. Local agencies are having difficulty in controlling the spread of tuberculosis and venereal diseases by migrants and in taking care of children suffering from malnutrition. It was the hope of the Committee that the federal government in coöperation with the states would accept responsibility for assistance to these people.

• The U. S. Civil Service Commission will hold examinations for the following positions in the Indian Field Service (including Alaska): public health nurse, $2000 a year; graduate nurse (general staff duty), $1800; nurse technician (bacteriology and roentgenology combined), $1800. Closing dates for the receipt of applications are : July 21 from Arizona, California, Colorado, Idaho, Montana, New Mexico, Oregon, Utah, Washington, and Wyoming; July 18 from all other states; November 7 from points in Alaska south of the Arctic Circle; and January 9, 1939, north of the Arctic Circle. An announcement may be obtained from your postoffice or from the U. S. Civil Service Commission, Washington, D. C.

• The New Jersey State Organization for Public Health Nursing held its annual meeting in Atlantic City on May 20. The following officers were elected for 1939: President, Nellie Ogilvie; Vice-President, Edith Granger; Treasurer, Grace P. Remshard; Recording Secretary, Emma Kuhlthau; Corresponding Secretary, Evelyn T. Walker.

GIVING CREDIT WHERE DUE

"A Lesson Dramatized," which appeared on page 49 of the January issue of PUBLIC HEALTH NURSING, and was credited as being reprinted in part from "The Project Method," by Dorothea S. Yens, R.N., *Irish Nursing and Hospital World*, May 1936, was originally reprinted by that magazine from the February 1936 issue of *The American Journal of Nursing*, page 174.

(Continued on advertising page 5)

Our Readers Say . . .

THIS COLUMN was initiated in May as a forum for the expression of reader opinion. Only signed letters will be published, although the signature will not be used except with the writer's permission. The National Organization for Public Health Nursing is not responsible for opinions expressed in this column.

OUR STUDENT-NURSE READERS

TO THE EDITOR:

Our last group of students in Professional Problems has sent me the inclosed report regarding PUBLIC HEALTH NURSING magazine, which they reviewed in the course. I thought you might be interested in seeing it.

GRACE A. WARMAN, R.N.
Principal, The Mount Sinai Hospital School of Nursing, New York, N. Y.

. . . . .

In any magazine, a variety of articles is necessary if the magazine is to circulate among a large group of people. Even among a group which has a common interest one will find a great many different thoughts and opinions. In PUBLIC HEALTH NURSING, the official publication of the National Organization for Public Health Nursing, there is a variety of printed material to appeal to a great many nurses.

The new public health nurse looks for articles dealing with stories of experiences of other nurses in the field. A great deal can be learned by reading about the experience of another nurse and her account of how she dealt with a novel situation.

In a group of ten students chosen to discuss what in their opinion was the best type of article in the PUBLIC HEALTH NURSING magazine, the majority preferred the educational type of article. This, of course, embraces a wide scope of subjects. Special mention was made of the subject of maternal health. In the April 1937 issue there is an article by Anna R. Moore called, "A State Maternity Demonstration Center," in which is described the educational program given to expectant mothers. This is one ideal way in which public health nurses, as teachers, are able to spread the knowledge of intelligent antepartum, confinement, and postpartum care.

In the May 1937 issue, there is an article called, "Health Teaching in a Secondary School." It reveals to us how much public health teaching means to the students, who benefit a great deal from lectures given them on various subjects such as tuberculosis and sex hygiene. In the article, "Habit Training During the Preschool Years," in the November 1937 issue, we are shown the importance of continued health supervision and child guidance on the part of the nurse, who imparts her knowledge to the mother.

We emphasize, then, those articles that encourage and teach more intensive participation between the public health nurse and the "unsick" lay person. We have only to look to the parent-teacher organization for a splendid example of better child training brought about by the coöperation of teachers and parents. Let the public health nurse join the organization and we will have a perfect trio in attempting to accomplish more intelligent living among the people.

LUCILLE PAISNER, *Chairman*

A CORRECTION AND AN EXPLANATION

My attention has been called to an erroneous statement made by me in the summary of the "Report of the Functions Committee" which appeared in the April number of PUBLIC HEALTH NURSING, to the effect that the magazine was a present to the National Organization for Public Health Nursing "from a group of Cleveland women." This is not so, for the magazine was a gift to the Organization from the Visiting Nurse Association of Cleveland. Acceptance of the gift was, however, made possible for the newly formed and impecunious little organization by the generosity of the group of women referred to, who carried a large part of the responsibility for publication, both financially and otherwise, until the organization was in a position to take over. To these women, particularly to three of their number, Mrs. Perry W. Harvey, Mrs. John H. Lowman and Miss Annie M. Brainard, I feel that the National Organization for Public Health Nursing should pay special tribute, as well as to the Visiting Nurse Association of Cleveland, from whom the original gift of *The Visiting Nurse Quarterly* came.

MARY S. GARDNER, R.N.
Providence, R. I.